Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0350 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Clayton Eugene Hagan 10:45 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Golden Living Center Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 7/3/1939 **Funeral** 1 X M 2 □ F Months Days Hours Min Director 220-34-2448 70 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Machael Examinar must be notified at Director 1X Yes 2 No Frederick Brunswick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 USA Funeral 2 East A Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours atter 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X**No 1 ☐ Yes 2 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If ten 27 is marked other the any injury or other transmitted. Federal Gov. Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Luther Hagan ပ Mary Josephine Hawes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21716 2 East A Street, Brunswick MD <u>Bonnie Hagan, Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/21/2010 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory Hagerstown MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Larvace A Williams John T Williams Funeral Home, Brunswick MD. 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** STAGE KEWAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate performe 2 No 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Records, Division of Vital within 24 hours after death

To the Funeral Director:
completely filled in by the f

Baltimore, Maryland 21215-0036

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier With

29d. Date signed (Month, Day, Year) 01-21-2010

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK MD 21701. KAZMI, MD 814 1011 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mary				nd Mental Hy	/giene	0.1.0	0.0500			
			State Registrar		Cer	tificate of E	Death		Reg. No.	UIU	03502			
	Physicia	ın/	1. Decedent's Name (First, Middle, La	•				2. Date of Do Month	eath Day	Year	3. Time of Death			
	Medic	al	Martha A. 4a. Facility Name (if not institution, given	Kephart		# 01 T		Month	-	10	11845 "			
	Examin	er		_	1 0	4b. City, Town, or		1 1		nty of Death				
	Funeral			Sex 7. Age (In	al Center yrs. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8 Date of Bi	rth	Vegat 9-Birtho	olace (State or Foreign			
	Director		218-16-4010	1 □ M 2 X F	34 Yrs.	Months Days	Hours	Min. Dec. 1	8, Year) 1925	Coun				
	T ow		Usual Residence of Decedent 10a. State 10b. County		0 7									
	rylan I-f sh ied a	ç			c. City, Town or Lo	cation				1	0d. Inside City Limits 1 Yes 2 No			
	r 28a notif		WV Minera 10e. Street and Number	1	Key	10f. Zip Code	-		10g. Citizen o	f M/h = h C = v =				
	vith th	Funeral Director	507 St. Cloud	Ctroot			6726		Tog. Citizen c		itry ?			
	ems ems	Ë	11. Marital Status	12. Was Decedent Ever	in U.S. 13. \			n? (Specify Yes or No Puerto Rican, etc.)	- 14. B	USA ace - Americ	an Indian.			
စ္	ter de , or it imine	by F	1 ☐ Never Married 2 🔀 Married					Puerto Rican, etc.)	В	lack, White,				
8	urs af ural" al Exa		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		☐ Yes 2 📉 No	Specify:		Speci	ify: Wh:	ite			
5	72 ho 1 "nat ledica	Completed	15. Decedent's (Specify only highest of		(Give I	ent's Usual Occup	ation during most o	of working	16b. Kind of	Business Inc	dustry			
12	ithin ene.	8	Elementary/Seconday (0-12)	College (1-4 or 5+)	ı	ONOT use retired)	Musici	ian	Muci	le Band	.a			
<u>0</u>	led w Hygi other	Be	17. Father's Name (First, Middle, Last)	1101	-DSTCHAT		's Name (First, Middle			<u></u>			
<u>la</u>	l be fi lental rked ric ev	유	Clyde Paugh					tha Trenum		,				
Maryland 21215-0036	hould and N is ma		19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	g Address (Street a	and Number	or Rural Route Numb	er, City or Town	, State, Zip C	Code)			
	and 2 s Health tem 27		Rhonda S. Reid/G	Granddaughter	176	l6 Broadf	ording	g Road Ha	gerstow	m. MD	21740			
ore	e 1 au t of H If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 i		20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location	n - City or To	own, State			
Ē	Pag tment tant: jury o		4 ☐ Donation 5 ☒ Other (Spec	Entombment				2/2010	Pompa	no Bea	ach, FL			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fameral Service Like	The State	£ 22	. Name and Addres		Smith Fun						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	Dhimfathis		shock, or heart failure. List only Immediate Cause (Final		NA.	Λ	0.655	4			Interval Between Onset and Death			
7	Physician, Medical		disease or condition resulting in death)	a. Due to (or as a co	usequence of):	yo cond	191	schel	r, a.	-				
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):					/3				
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	ate be executed hysician and the burial-transit	al E	resulting in death) Last	Due to (or as a co	nsequence of):									
9	cate be physic the bu	dical		d						-				
687	artifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy	_								
XO	ath certifica attending p	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 4 Pregnant at tim	Fetal death 3	Ectopic pregnanc Other (specify)	·y			Date of delive Month	ery Day Y ear			
Ö.	t the dea by the a tached t	Physician/Me	1 Yes 2- No 9 Unknown	9 Unknown										
<u>P</u> .	that the ned bedeta	by P	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?			
Š,	v requires that s been signed t should be det	ed k	CVA					1 🗆	Yes 2 No	3 🗆 Prob	bably 4 🗆 Unknown			
Ö	w req s bee	Completed						24a. Was			psy findings available			
3e	sician: The law r certificate has k irector, page 2 s	mo;							ormed? 2. No	death?	mpletion of cause of			
<u></u>	Physician: T r this certifica ral director, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death	(Check only one)	2.0 110					
₹	hysic his ce Il dire	은	1 Yes 2 No		2 ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗌 Nurs	sing Home 5 Res	idence 6 🗆 O	ther (Specify))			
jo	ding P. th. After t funera	Certificate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c. Injury work	?		how injury occu	ırred				
Š	r Attend er death rector: / by the f	tific	2 Accident Investigation 3 Suicide 6 Could not	be	Albana fama aka		Yes 2 □ N							
Division of Vital Records, P.O. Box 68760	spital or A	Cer	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	et, factory, office			(Street and Num wn, State)	ber or Rural	Route Number,			
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exam	knowledge, death o	ccured at the time,	date and pla	ace, and due to the ca	ause(s) and mar	ner as state	d.			
	To the Hos within 24 h To the Fun completed	Me	only one) 3 Certifying Nu	rse Practioner: To the best	of my knowledge, o	eath occurred at the	e time, date a	nd place, and due to the	he cause(s) and	manner as sta	ated.			
	5		29b. Signature and title of certifier		. 4.4	29c. License	697	27	29d. Date sign					
				SANIKOR	-		- (/	1	Lanu	ary	28,2010			
			30. Name and address of person who Sudheer Saniko		, , , , , ,	,	Road	Cumberlan		21502				
	Stat		31. Date filed (Month, Day, Year)	32. Redistrar's 5	Signature					<u>~+JV</u>				
	Registra		FEB 12	2010 Beneva	p. A.	arked	-							
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DHMH 17 Rev 7/2009

		For State	State of Maryland		nt of Health and I ete of Death			0 0050			
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Physicia Medic	cal	Pauline 4a. Facility Name (If not institution, give s	Latonto	Cine 4b. Cit	y, Town, or Location of Death	January		0610 A			
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uneral irector		211.18.3612	7. Age (In yrs. la	ast birthday) If Und Months	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Fore Country) [aryland			
w.	1	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location		*	, ,	10d. Inside City Lim			
-fsho fied a	ţ	MD Baltimo	ore B	altimore				1 □ Yes 2 🏋			
or 28a e noti)irec	10e. Street and Number			ip Code	1	0g. Citizen of What	Country?			
23a ust b	ral	2523 McCo.			21222	:'6- V N		States			
Department or result and worlder in yearle. The most state of the most is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of Hispanic Origin? (S pecify Cuban, Mexican, Puer 2X No Specify:	to Rican, etc.)	Black, Wi				
atura cal E		15. Decedent's Edu	cation	16a. Decedent's Us	sual Occupation	rkina	16b. Kind of Busines				
Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		vork done during most of wor use retired)	Killy					
her th		11 17. Father's Name (First, Middle, Last)		Homema		ne (First, Middle, I		Own Home			
ed of	9 Be	Amos Spratt				r Angle	naiden Gamaine)				
mark	은	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing Addre	ss (Street and Number or Ri		r, City or Town, State	e, Zip Code)			
27 is		Paulette W. Price	e/Daughter	2523 McCc	omas Avenue,	Baltimore	e, MD 212	.22			
f Item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Cé	ace of Disposition (A emetery, crematory o	lame of r other place) Febr	Date uary 3,	20c. Location - City	or Town, State			
tant:		4 □ Donation 5 □ Other (Specify)	Met	rry Hill hodist Ce	metery 2010) 1	Cherry	Hill, MD			
Impor any in		21. Signature of Funeral Service Licens	"Hi has	Hicks 103 W	and Address of Facility Home for Fur Stockton St	nerals, P	.A. kton. MD	21921			
/sician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death ne cause on each line.	. Do not enter the m	ode of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Deat			
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anner	<u>.</u>	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinitediate b. Due to (or as a consequence of):									
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phys s the	edical		J								
he attending I ed for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome pf pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic			23d. Date of Month	delivery Day Year			
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signe d be	d by	Dementia		relen	-	1 □ Y	es 2 1 No 3	Probably 4 Unkr			
shoul	Completed		/			24a. Was a	an 24b. Were	autopsy findings avai			
certificate has t irector, page 2 s	dwo					autop: perfor 1☐ Yes	med? death				
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i. After th funeral		27. Man of Death 1 Platural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred				
Olrector: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, street, fact	1 ☐ Yes 2 ☐ No tory, office	28f. Location (S City or Tow		Rural Route Number,			
within 24 hours are locati. To the Funeral Director: After this certifice completely filled in by the funeral director, it	Medical Ce		sician: To the best of my kno iner: On the basis of examina and manner stated.								
witiliti То the соттріє	Mec				29c. License number	- 2	29d. Date signed (M	onth, Day, Year)			
> - 0		30, Name and address of person who constructed and itself of certifier and itself of certifier and address of person who constructed and address o	mo)27220		2/1/10				
							- 1				
		30, Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	1 114	March.	md 11	12/			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 2010 0820 A January 30 <u>Elizabeth Ann Mason</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1144 Calvert Road Rising Sun Ceci1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F DEC 9, Director 212-52-6722 61 1948 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Show event, the Medical Examiner roust be notified at 1 ☐ Yes 2 X No Director 28a-f Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 1144 Calvert Road 21911 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Iter 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales/Customer Service Power Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walton R. Mason မ S. Mildred McDowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Mason/Self 1144 Calvert Road, Rising Sun, MD 21911 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place)
Friends Burial 20a. Method of Disposition 20c. Location - City or Town, State February 4 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Calvert, 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Hicks Home for Funerals, 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any locality is in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to (or as a consequence of) the attending physician and hed for use as the burial-transit Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 ☑ No 2 ANO 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Martha Hosford, M.D., 111 W. High Street, Suite 104, Elkton, MD 21921 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month MOUSAV andare

1. Decedent's Name (First, Middle, Last) 3. Time of Death 243A Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner riner Georg Hospita anham ommunity 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (In yrs. last birthday) If Under 24 Hrs. Funeral (Month, Day, Country) 1 X M 2 □ F Hours Min. 3 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director Greenbel Yes 2 No Cheorges 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 20770 Mathew Street IRAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DQ NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4, or 5+) Dealership lesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ MOUSAV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brethe JAHANSHA 04 MA 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 25/2010 4 ☐ Donation 5 ☐ Other (Specify) Muslim Funeral Ser 22. Name and Address of Facility Actem Signature of Funeral Service Licenses Woodbridge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. terval Between nset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examine nous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami The law requires that the death certificate be executed the burial-transit and r as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No Yes detached 9 Unknown P.O. cate has been signed by page 2 should be detact Other significant conditions of ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PR/Outpatient 3 DOA 1 Inpatient 27. Manner of eath 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Division Investigation
6
Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature 2010 16 who completed cause of death Utem 23a) (Type, Print) Road 20706 State

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		Plea	se Type or						_		_		
		For State Registrar	State o	of Marylan		rtment of F		nd Me	ental Hy	/gien Reg. N	001/	1 0	3506
Physicia	an	1. Decedent's Name (First, Middle James L. Mu							2. Date of De Jan . 2	eath D	2010 Yea	r	ime of Death
/Medic Examin		4a. Facility Name (If not institution Prince Geor	, give street and nu	mber) spital		4b. City, Town, o Cheve:			J (11 • 2	4	c. County of De		• 121
Funeral Director		5. Social Security Number 223-32-7464 Usual Residence of Decedent	6. Sex 1 3 M 2 ☐ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bi (Month,D March	rth ay, Yea	777	Birthplace (S Country) Virgi	State or Foreign nia
Maryland a-f show fied at	tor	10a. State D • C • 10b. County	ρ.		y, Town or Loc shing								side City Limits
th with the 23a or 28a ist be noti	al Director	10e. Street and Number 3932 Blaine	Street	N.E.		10f. Zip Code 2001	9				U.S.A.		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marria 3 □ Widowed 4 □ Divorced	Armed F	2√ No ive No	l'	Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 ☑ No	lispanic Orig an, Mexican, Specify:	gin? (Spec , Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Al Black, W Specify:	hite, etc.	
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and 2 shou ealth and M n 27 is mar ier traumat	Н	19a. Informant's Name/Relations Mary Murphy			3932	g Address (Street 2 Blain		Ν.	E. Wa	shi	ngton	D.C.	20019
t. Pages 1 tment of He tant: If Iten		20a. Method of Disposition Burial 2 Cremation Donation 5 Other (S	pecify)	0	emetery, cren onBapt	sition (Name of natory or other place istChu	rch J	an30	0,10		ringto		a.
permi Depa Impo any Ir		21. Signature of Funeral Service	ERVO	Mser	Fi	Name and Addre Obinson Uneral	1313 Home	6t.			W.Wash		20001
Physician /Medical Examiner		shooth, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BLADDER CANCER Due to (or as a consequence of):											
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the death certificate be e. y the attending physician sched for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome pf pregna birth 2 □ Feta pnant at time of d nown	I death 3]Ectopic pregnanc] Other <i>(specify)</i> _	у				23d. Date of Month	delivery Day	Year
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	ation: To Be	25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig	Hospital: 1 28a. Date (Mo.		ER/Outpatien 28b. Time of Injury	f 28c. Inju Wo	ner: 4 🗆 Nui	rsing Hor		sidence	6 ☐Other (5	Specify)	
To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could determ	ined 26e. Plac build	ding, etc. (Specif	(y)	eet, factory, office			City or T	own, St			te Number,
the Hosp thin 24 hor the Fune ompletely fi	Medical			basis of examina nner stated.	ation and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time	e, date a	and place, and Date signed (M	due to the o	Year)
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3		30. Name and address of person	HUNE,1	ise of death (Item	n 23a) (Type,	TONST.	NW,	WA	361 NO	670	NDO	- 20	0016
Sta Registr		31. Date filed (Month, Day, Year)	Denvis	negistrar's Signa	faces	/							

Registrar

			For State Registrar	State of	Marylar	nd / Depa <i>Ce</i>	artmer rtifica	nt of ⊢ te of t	lealth a Death	and M	lental Hy	giene Reg. No.	201	0	035	507
	Dhyoisi		1. Decedent's Name (First, Middle,	,							2. Date of De	eath Day	Ye	ar	3. Time of	Death
1	Physici /Medio		Luis Emilio Mo	reno							Januar	y 28	, 201	0 .	3:00	Ам
4	Examir	ner	4a. Facility Name (If not institution,						Location of	of Death			County of			
			Frederick Memo			1		ederi er 1 Year	CK If Under	24 Hrs. I	O Data of Di		rede			- Familia
	Funeral Director		583-42-3973 Usual Residence of Decedent	6. Sex 7. 1 M 2 □ F	. Age (in yrs.	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D November	$\stackrel{\text{rin}}{=} 21,$	L950	Pue	ce (State o y) rto R	ico.
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							100	I. Inside Ci	ty Limits
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	h the	ire	10e. Street and Number	LLCK			_	p Code				10g. Citiz	zen of Wha	t Country	y?	
	th wit	<u>a</u>	1355 David Lane	е			2	1703				Un	ited	Stat	ces	
	r dea	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U e <u>s?</u>	J.S. 13.	Was Dece	edent of H	ispanic Ori an, Mexicar	igin? (Spe	cify Yes or No Rican, etc.)	0- 1	I4. Race - Black. \	Americar Vhite, etc		
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Example must be rediffied at	þ	1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1							to Ric		Specify:	Lat		
Baltimore, Maryland 21215-0036	ain 72 ho e. In "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education f grade completed) College (1-4	lor E . \	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	ork done d	durina mos	t of workir	ng	16b. Kir	nd of Busin	ess/Indu	stry	
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yla	Men Men arke	은	Emilio Moreno						Cai	rmen	Cruz					
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뜶	artme artme ortant injury		4 ☐ Donation 5 ☐ Other (Spansor) 21. Signatur of Funeral Service Li		Smi	thsbur				20	10				aryla	na na
Ba	permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Pulleral Service El	Censee	MO14	173 K	eney	and	Basi	ord	P.A. F	unera	1 Hon	ne,	d O	1 701
			23a. Pan 1. Enter the disease, o c shock, or heart failure. Lin o	complications that cau			er the mo	Unu de of dyin	rcn S ng, such as	cardiac c	t, Free	deric arrest,	K, M	Α.	Approximate	е
	Physician		Immediate Cause (Final												nterval Bet Onset and I	
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87	physic the I	dical	·	d										+		
9 X	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of prean	ancv							3d. Date o	f dolivor	,	
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birt	th 2 Feta	al death 3	Ectopic Other (s		У				Month			Year
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of Vital Records, P.	es tha	Completed by PI	Part II. Other significant condition	is contributing to deat	th but not res	sulting in the u	nderlying	cause give	en in Part I.			tobacco u			cause of d	
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Re	: The law cate has page 2 s	Ĕ									auto	psy	prio	r to comp	oletion of c	ause of
ta	ian: The rtificate tor, page	ပို	25. Was case referred to medical						06 Place	of Doodle		ormed? 2 X No	1	Yes 2	□No	
>	ysician: iis certific director,	m	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	natient 2	1 ER/Outpatier	nt 3 🗆 D	OA Othe			n <i>(Check only</i> me 5 ☐ Res		Other	(Cassifu)		
	g Phy ter thi	i.	27. Manner of Death	28a. Date of	Injury	28b. Time o		28c. Injur	v at		28d. Describe			эреспу)		
jo	트 . 등 등	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		Day, Year)	Injury	М	Work 1 □	Yes 2	No						
-	= e e	Certification: To	3 Suicide 6 Could no 4 Homicide determin	of be led 28e. Place of building	f Injury - At h	ome, farm, str	eet, factor	y, office		2	28f. Location City or To	(Street and wn, State)		or Rural F	Route Num	ber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the bas and manner	is of examina	owledge, deat ation and/or in	h occurred vestigation	d at the tir n, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the	e cause(s) , date and	and mann place, and	er as sta I due to ti	ted. he cause(s	;)
	To th withir To th comp	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Date	e signed (/	Month, Da	ay, Year)	
			10.11	m.				H0064	4135			Febru	ary 2	2, 20	010	
			30. Name and address of person w	ho completed cause	of death (Iter	m 23a) (Type,	Print)									
			Safrina Hasan, N	M.D. 400	West S	Seventh		eet,	Fred	ericl	k, Mary	land	2170	1		
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signa	ature	box	W								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 10, 2,010 Year Mutasa 1937 Euphimia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 1 0^{Mpn2} 4^{Mp} 1⁹⁹⁷ 7 5 500-08-2214 34 Zimbabwe Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene.
Health and Mental Hyglene.
The stream to 28a-f sho then 27 is marked of other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George' Laurel 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1020 West Court #10 20707 Zimbabwe Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Seconday (0-12) College (1-4 or 5+) Speach Pathologist School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Samuel Chimbadzwa Mutasa Joyce Gezimati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston L. Gray/Husband 1020 West Court #10 Laurel, Maryland 20707 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven 1 X Burial 2 Cremation 3 Regional from State 1/18/2010 Silver Spring, Md. 4 Donation 5 Other (Specify) 21. Signatu 9 PHINTPADESPINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 Onset and Death Immediate Cause (Final Complications due to renal biopsy Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Dar Examine Due to (or as a consequence or). e Hospital or Attending Physician: The law requires that the death certificate be executed a Puneral Birector. After this certificate has been claused. signed by the attending physician and defeached for use as the burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 X Yes 2 🗌 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury 1 Natural 5 \square Pending status post needle renal biopsy Division 2 Accident
3 Suicide
4 Homicide 7:46a 1 Yes 2X No 01/04/10 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Location (Street and Number or Rural Route Number, City or Town, State) Suburban hospital Bathesda, Maryland determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D60117 Jan.13,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Eric Park

31. Date filed (Month, Day, Year)

JAN 2 2 2010

M.D

Georgetown Road Bethesda, Md

8,600 old

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#24b, 26, 29 aperMD, 1/22/10, EM, MC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHRISTOPHER MICHAEL MEDDAUGH January •13n Medical 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>National Institutes of Health</u> <u>Bethesda,</u> Montgomery . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 ₹ M 2 □ F Davs Months Hours Min. (Month, Day, Year, 137-72-1125 Director 30 1979 May 4 New <u>Jersey</u> Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PAMontgomery Norristown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19401 1011 New Hope Street Apt 32 B United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. If Yes Give White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Pharmaceutical Research Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked or traumatic ever pe Gary Meddaugh Kathleen Maczko permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Meddaugh / Father 38 Summerfield Road, Belvidere, NJ 07823 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter & Ster Paul Alpha, New Jersey Signature of Funeral Service Licer 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg. MD art 1. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se (Final disease or an dition ्र hysician Unremitting resulting in death) Medical Due to (or as a con uence of) Examiner failure Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a son sequence of failus DIVISION OF VITAI RECORDS, P.O. BOX 68/60
Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit renal that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical hacoacremonium) intection Division of Vital Records, P.O. Box 68760 attending p use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ☐ Pregnam
☐ Unknown sbeen signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed' 1 ☐ Yes 2 🛛 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work 124 hours after death. le Funeral Director: Aft bleted filled in by the fur 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 9 Maryland DG 532

Registrar

State

10 Center Drive, Bethesda, Maryland 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Sweeney

31. Date filed (Month, Day, Year)

JAN 22

		For	State of Ma		d / Depa	artment of H	lealth and M			gible.		- 1 0
		1 - State Registrar			Cei	rtificate of l	Death	2. Date of Dea	Reg. No. 2	0 1 0	3. Time of E) U
Physicia		1. Decedent's Name (First, Middle, Last) Leo P Myers						Month 1	Day 21	2010 2010	1:30	AM
/Medica Examine		4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of Death			ounty of Death	1	
Zxamin		Lorien Mt. Airy				Mt. Air	У			rroll		
Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. la	nst birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 6/6/	h y, Year) 1020	Coul	place (State or ntry)	
Director		705–12–4999 112 Usual Residence of Decedent		89				0/0/	1920	Clar.	lés Tow	11 WV
ryland		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City	
he Ma 28a-f s	Director	MD Frederick		Knox	ville	401 71- 0-1-			40~ Citi-a	n of What Cour	1 Tes	
with the		10e. Street and Number 1428 Souder Road				10f. Zip Code 21758			US		ury?	
death	Funeral		2. Was Decedent	Ever in U.S	13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		. Race - Americ		
or ite		1 Never Married 2 Married	Armed Forces? 1 XYes 2 1 If Yes, Give	No	1	ir ves, specify Cuba 1 ∐Yes 2 ∑ No	Specify:	o Rican, etc.)		Black, White,		
hours ural",	od by	3 □ Widowed 4 □ Divorced	Year or Dates:			dent's Usual Occup	ection			of Business/In		
in 72 n "nat	plete	15. Decedent's Educ (Specify only highest grade	completed)	>	(Give	kind of work done of DO NOT use retired	durina most of wor	king	TOD. Killa	or business/in	uusti y	
d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5	»+)	Insp	ector			Rail	road	_	
be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan	,				
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Exprirer must be rediffied at	ရ	George William Mye			405-14-10	Add (Ctract	Blanche				Cadal	_
id 2 st Ith an 27 Is r traur		19a. Informant's Name/Relationship (Type Frances E Lee, Da	ughter		!	ng Address <i>(Street</i> Arnolds t					Code)	
is 1 ar of Hea item;		20a. Method of Disposition		20b. Pla		osition (Name of matory or other place		Date		tion - City or To	own, State	
Page nent c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			ts Cemetery	1	/2010	Bruns	wick N	1D	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriser must be rotified at once.		21. Signature of Funeral Service License	e 1/1/1/2	salo1	, i	2. Name and Addre	•	7 **	Dec 2007 2	id- MD	21716	
20 2 8 0		23a. Part 1. Enter the disease, or complic	cations that caused	the death	-	Ichn T Will:				ICK MD.	Approximate	
Dhysisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	ne. į		- Den		or respiratory a	,,		Interval Bety Onset and D	veen
Physician /Medical		disease or condition resulting in death)	 Due to (or as			Nem	cutia			-		
Examiner		Sequentially list conditions.										
ted sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):							
execun and ial-tran	Examiner	that initiated events c resulting in death) Last	Due to (or as	a conseque	ence of):							
eath certificate be executed attending physician and for use as the burial-transit	cal	d										
ertifica ling ph e as th	Physician/Medi	IF FEMALE:			4500			10.000				-
attend for us	ian/	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[☐ Ectopic pregnand	су		23	 d. Date of deliving Month 		'ear
the do	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	it time or de	Jan 51							
uires that the de signed by the a d be detached f	by P	Part II. Other significant conditions con	tributing to death b	ut not resul	lting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	/	
w require s been si should b	ted	Coronary M	tery Di	slas				1 🗆 '	Yes 2	No 3∏ Pro	bably 4 🔀 U	Jnknown
e law i has b	Completed							24a. Was autop	osy		opsy findings a empletion of ca	available ause of
n: The ficate r, pag								1 □Yes		death? 1 ☐ Yes	2 □ No	
rsicial s certii lirecto	o Be	25. Was case referred to medical examiner?	ospital:	ent 2 🗆 E	=P/Outpatio	nt 3 T DOA Oth	26. Place of Dea	ath <i>(Check only c</i> Home 5 ☐ Resi		Other (Spec	(64)	
g Phy ter this neral o	Ë	27. Manner of Death	28a. Date of Inju	ıry	28b. Time o		rv at *	28d. Describe			19)	
endin eath. or: Af he fur	atio	1 Natural 5 Pending investigation	(MONIN, De	ly, rear/	n july		Yes 2 □No					
or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At hor c. (Specify	me, farm, str	reet, factory, office		28f. Location (City or To		Number or Rur	al Route Num	ber,
		29a. Certifier Certifying Phys	sician: To the best	of my know	vledge, deat	th occurred at the ti	me, date and place	e, and due to the	cause(s) a	and manner as	stated.	
n 24 h	Medical	(Check only 2 Medical Examination)	ner: On the basis of and manner st		ion and/or ir	nvestigation, in my	opinion, death occu	urred at the time,	date and p	lace, and due	to the cause(s)
Voithi Comp	Ž	29b. Signature and title of certifier				29c. Licens				signed (Month		
		1/4/	1	MO		100	059423	·	Janu	ary 21	2010	
8+1VA		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print) Field Cou	int ist A	9 Man	-246.1	lle xx	3 2110	u
Stat	е	31. Date filed (Month, Day, Year)	32, Registr	rar's Signati	ure	1 101	t t	1 1 1001	IVINA	1	- 410	
Registra	r	JAN 22	ZUIU	RYLKAS	J.	GO aver						

10-00826 Ту

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ree Justin No	rris	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 20 0 35 1											
Physicial edical Exami		1. Decedent's Name (First, Middle,Last) Tyree Justin Norris					2	Date of Deat Month January 29	h Day Y	ear	3. Time of Death 1024 hrs		
		Facility Name (if not institution, give street and number) Union Hospital	41	b. City, Tov Elkton	n, or Lo	ocation of	Death	oundary 2	4c. Count Cecil	y of Deat	h		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 1 2 F 20	y) Yrs.	If Under	Year Days	If Under : Hours	24Hrs. Min.		, 1989		rthplace (State or gMaryland puntry)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years 17. Father's Name (First, Middle, Last) Cary Eugene Norris, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Married Armed Forces? 1	B. Was If Ye I I I I I I I I I I I I I I I I I I	Edge 10f. Zip Co Decedent s, specify Co Yes 2 X s Usual Oc st of workin e Ver	of Hispacuban, No cupation g life. Demp	21040 anic Origin Mexican, P specify: n (Give kir NO NOT us 1 0 yedMother's l	? (Spectrum Report of Repo	rk done first, Middle, M CSA Ly ral Route Num	Specify 16b. Kind of I 16b. Kind of I ne taiden Suman nn LeW ber, City or To	U.S ce - Amerite, etc. :: :: :: :: :: :: :: :: :: :: :: :: ::	.A. ican Indian, Black, Black Black Industry employed		
1										Maryland			
/Madical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Myocarditis complicating convenital abnormality of Due to (or as a consequence of): the brain b											
oe executed cician and urial - transit	dical Examiner	XUNPENDED AMENDED 27. Der ME G902 4/30/10 TT											
Box 68760, te death certificate be extite attending physician and for use as the burial	8	23a, 27, per ME G9(IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23a, 27, per ME G9(1 Live birth 4 Pregnant at time of death 9 Unknown	Feta	4/30/ Ideath er (Specify	3	TT Ectopic p	regnand	sy	23d. Date of Month		y Day Year		
cords, P.O. law requires that the has been signed by 2 should be detact	Completed by P	Part II. Other significant conditions contributing to death but not resulting in t	the un				_	1 Yes 24a. Was a autops perform 1 Yes 2	2 ✓ No 3 in 24b. sy ned?	Prol	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No		
'ital sician: is certi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpat	tient			Death (Cl			Residence 6	Othe			
ion of Vital Rectending Physician: The leath. or: After this certificate the funeral director, page	ation: To	1 ✓ Yes 2 No I I Inpatient 2 ✓ ENOUpat 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time			. Injury	at Work?	28		ow injury occu		·		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Suicide (Specify)	street,	factory, of	fice buil	ding, etc.	28	3f. Location (S or Town, St		ber or Ru	ral Route Number, City		
Fo the Hos within 24 h Fo the Fun completely	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.											
	Σ	299. Signature and title of certifier Wouge to The Unul			cense r O.C.M.				January 3		nth, Day, Year)		
			1 Pe	nn Stree	t, Balt	timore, I	MD 21	201					
St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 3 2010 Registrar's Signature		V									
DHMH 17 Rev 1/20	001	ORIGI	NAL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:05 Margaret Ellanora Osborne 2010 January 24, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Director 217-42-7885 85 November 21, 1924 Washington, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any filury or other traumatic event; I'm Modical Evaminer must be retified at any injury or other traumatic event; I'm Modical Evaminer must be retified at any injury or other traumatic event. 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County 1 XYes 2 □ No Directo Manchester Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Main Street 21102 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County School System Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Allen Hayes Edith Clementine Neff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1195 Fish and Game Road, Littlestown, PA 17340 Thomas E. Osborne / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Hyattsville, MD 20781 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician reavs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to instance ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. I or Attending Physician; The law requires that the death certificate be a after death.

Director: After this certificate has been signed by the attending physician in Inky the funetal director, page 2 should be detached for use as the burist. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day ı ∟Yes ZNo 9 □ Unknown Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ANursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ZNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

apr 31. Date filed (Month, Day, Year)
JAN 2 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVIS	aryland / Depa <i>Cel</i>	artment of He rtificate of D			lene eg. No⊋ ∩ ∩	03513
	Dhurisi		Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
ta	Physicia /Medic		ANNA LENORA OSBORNE				JAN.31		8:25P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 5509 JEFFREY CIRCLE		4b. City, Town, or L			4c. County of Dea	ın
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)			8. Date of Birth (Month, Day, 8 – 1 – 1		thplace (State or Foreign ountry)
П	Director		577-46-2932 1 ^{1 M 2} X ^F	7.4 Yrs.	Months Days	Tiodis Iviili.	8-1-1	935 WAS	SH",D.C.
	ow it		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	MD. CHARLES	,	WALDORF				1 □Yes 2X No
	with the 3a or 28 I be no	I Director	10e. Street and Number 5509 JEFFREY CIRCLE		10f. Zip Code 2060	1	I	0g. Citizen of What Co $U.S.A$	ountry?
36	be filed within 72 hours after death with the Maryland the Wighen. It has "been then "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates;	No I	Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
9	2 hour	ted t	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupat	ion		16b. Kind of Business	/Industry
Maryland 21215-0036	ithin 7. ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life. I	kind of work done du DO NOT use retired) CHASING	•		DEPT. OF U.S.GOVT	
2	iled w Hygier ther th		1. Father's Name (First, Middle, Last)	POR				Maiden Surname)	•
au	be d d	To Be	UMBERTO CONTE			ROSE C		,	
lary	should I and Men is marke	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street ar.	nd Number or Run	al Route Number	r, City or Town, State,	Zip Code)
	alth 27 27 37		LAURA SWICK-DAUGHTER	1222				MD.20601	Taum Photo
Baltimore,	o ° ± ≿		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crer	osition (Name of matory or other place) EM • GARDE	NS 2-4-	2010	20c. Location - City or WALDORF, I	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Fugeral Service Licensee M0047	79	2. Name and Address RAYMOND LA PLATA	of Facility FUNERAL	SERVI	CE, P.A.	
			23a. Part 1. Enter the disease, or complications that aused shock, or heart failure. List only one cause of each li	the death. Do not ent					Approximate Interval Between Onset and Death
The said	Physician		Immediate Cause (Final disease or condition resulting in death)	nce	9)	Lun	9		Oriset and Death
أتمر	/Medical Examiner		Due to (or as	a consequence of):	Q	()		
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60,	ifficate be executed g physician and as the burial-transit		Due to (or as	a consequence of):					
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	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year
σ.	res that the signed by be detact		Part II. Other significant conditions contributing to death b	ut not resulting in the u	ınderlying cause giver	n in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
rds	w requires s been sign should be	ed by					1 □ Y	es 2 □ No 3	Probably 4 ☐ Unknown
Records,	Physician: The law re this certificate has bee al director, page 2 sho	Completed					24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
Vital	clan: sertifica sctor, I	Be	25. Was case referred to medical examiner?			26. Place of Deat			
of	Physi rthis ral dire	٦.	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpation 27. Magner of Deat 28a. Date of Inju	ent 2 ER/Outpatier		4 LI Nursing Ho		ence 6 Other (Sp.	ecify)
on	nding Fith. :: After e funer	tion	1	ny, Year) Injury	Work?	es 2 □No	204. 90001.00 11	ow injury occurred	
Division of	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, to	Certification:	3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one)	of examination and/or in					
	To the within 2 To the complex	Me	29b. Signature and title of certifier		29c. License	number	2	29d. Date signed (Mon	th, Day, Year)
			* Hall		09	+35)	2/2/	10
			30. Name and address of person who completed cause of o	03 (SPrint) Print)	tes 1	20	206	46
	Sta Registr		31. Date filed (Month, Day, Year) 32. Pegistr	rar's Signature	tall!				7,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1/20/2010 Jay R. Penn M 23:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min Month, Day, Year) 8/8/1949 Director 008-38-7713 60 Rutland, VT Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MDPrince George's Chillum 10e. Street and Number õ 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be and 2 should be filed within 72 hours after death with theath and Mental Hygiene. Theath and Mental Hygiene ten "natural", or items 23a tien 27 is marked other than "natural", or items 23a ther traumatic event, the Medical Examiner must by ther traumatic event, the Medical Examiner must by Funeral 1112 Oakdale Drive 20782 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker 4+ NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy O'Shea Donald C. Penn, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald C. Penn, Jr. / Brother 1112 Oakdale Drive, Chillum, item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 1/24/10 Metropolitan Crematory Alexandria, Virginia Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue RAG Rogers Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Right Physician/ wowlo neuwon 4 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Dav Yes 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 2 No eral Director. After this certific filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ျှ 1 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury ☐ Accident☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Operatifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and ti 29c. License number D0055120 MID 21 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue SE Soute 310 Was holy for DC 20032 in ARD Parkmen MD 1328 Southern 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Parker-Ford 2010 1858 Medical anuary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 5, 1942 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min. Months 085-34-5388 Director 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD PG Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9006 Trubador Drive 20735 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alberta Parker Abe Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8918 Ballard Lane Vincent Parker/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/29/10cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Luke Church Cemetery Ellerbe, NC of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H Suitland, Md. 20746 3910 Silver Hill Rd., 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner rdiovascular terioscerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ean Due to r as consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year certificate has been signed by the rector, page 2 should be detached a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? orbid 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2X No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. M.D. 29c. License number

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Registrar
DHMH 17 Rev 7/2009

30. Name and address of re-

run aston Ra

Ft. Washington, MD

who completed cause of death (Item/23a) (Type, Print)

noton

11701L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I tem 26 per phys. G900 2/9/10 dk
State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 10:42 PM 10 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1504 AIRPORT LANE ACCOKEEK PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-27-1952 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Yrs. VIRGINIA 212-62-2397 Director 57 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examinar must be nutilied at Director 1 ☐ Yes 2 ▼ No CHARLES WHITE PLAINS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11064 DeMARR ROAD Completed by Funeral 20695 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify 3 ☐ Widowed 4 ☐ Divorced Specify:WHITE 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) SAFEWAY FOOD STORE <u>MANAGER</u> Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H tant; If item 27 Is marked out Be GEORGE KLINE PHIPPS RUTH FRANCES MATTHEW ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY FOX-SISTER 1504 AIRPORT LANE ACCOKEEK, MD. 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State TRINITY MEM GARDENS 1-29-2010 WALDORF, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee MQ0479 LA PLATA, MARYLAND 20646 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Nelanoma > 6 mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the charge Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trai Due to (or as a consequence of): 和 / De 地名 Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 HInknown 9 Unknown is certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 \(\text{Precidence} \) 6 \(\text{Other} \) Other (Specify) \(\text{home} \) Sister's 1 ☐ Yes 2 🚾 🕅 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIEGER MI 31. Date filed (Month, Day, Signature State Registrar

D/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2010 Month Year Physician/ 19, P^{M} Jan. Evelyn Roach Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7507 Grouse Place Prince George's Landover 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 □ M 2 🛱 F Days Hours Months Min 1930 South Carolina Director 577-44-9451 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 K Yes 2 No Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 United States 7507 Grouse Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 1 No Yes, Give Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Domestic Care Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dock Snow, Sr. Elvira Legget 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grouse Place Landover, Maryland Mildred Henson/ Daughter 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date January 23, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Landover, Maryland 2010 Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examil sician and burial-transit that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed plnous been Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? 2 \square No 2 X N 1 Yes Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 **X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 53235 January 22, 2010

Registrar

13635 Baltimore Ave. South Lakes Ofc. Park Laurel, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darryl A. Hill, M.D. FACP

31. Date filed (*Month, Day, Year*)

JAN 2 6 2010

10-00866 Robert Barnett R			rint in Black Indelible Maryland / Department of Certificate of	of Health and Mental H	_	2010	03518
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Funeral Director		5. Social Security Number 6. Sex 1 M	7, Age (In yrs, last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_ `	MM/DD/YYYY) 9. Bird Foreig Con	
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arylan	Director	10e. Street and Number	T GOHOWING	10f. Zip Code	10g.	Citizen of What Cour	ntry?
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Vita hysician this cer	Be	examiner? 1 ✓ Yes 2 No	II: 1 Inpatient 2 ER/Outpatie	Tout		sidence 6 🗸 Other	: Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raster death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	\vdash	27. Manner of Death 1 Natural 5 Pending	3a. Date of Injury (Month, Day, Year)	1 Vac 2 X No	26d. Describe how unk	v injury occurred	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Puneral Director: After this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 \overline{X} Could not be	8e. Place of Injury - At home, farm, str Specify) found at hom	reet, factory, office building, etc.	28f. Location (Street or Town, State Conowing	eet and Number or Ru e) 632 Moun go, MD	ral Route Number, City t Zoar Rd
E Hospital		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, death occ				
Fo the H within 24 Fo the F	edical	one) 2 Medical Examiner: On the	e basis of examination and/or investion nanner stated.	gation, in my opinion, death occurred a	at the time, date an	d place, and due to the	e cause(s)

30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifie

Medical Exa...

32. Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 31, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florence Robison Medical 4a. Facility Name (if not institution, give street and number) County of Death or Location of Death Examiner eninswa Regional Medieni Salisburg Willmico If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ⋤ F Months Days Hours Jan 29 Your 1923 Countre 297-12-2961 87 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at hours after death with the Maryland Director PARSONSBURG MD WICOMICO 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33784 BOB SMITH RD. 21849 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 V Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) the GENERAL DUTIES HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked ot traumatic ever 0 ALBERT SIGLER MARY YOST permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY A. MOTZ 8822 OAKHURST AVE. S.E., WAYNESBURG, OH 44688 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3X Removal from State CANTON, OH SUNSET HILLS MEM.GARD: 2-9-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES 416 FEDERAL ST. MILTON, DE 19968 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ascus disease or condition resulting in death) > your Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from the list conditions, from the list cause. Enter Underlying Cause (Disease or linjury Examine Due to for es e consecuence offiattending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autonsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital 24 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) byha Natura D051359 2nd 2010

State Registrar HIS . S. DIVISION

gistrar's Signature

SHISBURY MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN

DR. USHA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:10 pM Deborah Roth 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7502 Lilac Sea Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 □ M 2 🗓 F 0877777949 Washington. DC Director 220-44-7579 60 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 Y No Columbia Maruland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7502 Lilac Sea 21046 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 X Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sidney Klopman Sulvia Orlove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacob B. Roth - Husband 7502 Lilac Sea. Columbia, Maryland 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury (4 Donation 5 Other (Specify) Judean Memorial Grdn. 01/22/2010 | Olney. Maryland 21. Signature of Funeral Service Licen Le 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Renal Disease disease or condition resulting in death) WOATS Medical Due to (or as a consequence of Examiner Gastric Bypass Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Dav Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. I signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy certificate ! Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0052089 January 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Brandermill Blvd., Suite 220, Gambrills, MD 21054 Ruth Gallatin, 31. Date filed (Month, Day, Year) State 2010

Registrar

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		For StateAmen Registrar	ded#26pe	erMD FCH	D,KS	1/2	2/1 e er	tificate of I	Death	vicinal riy	Reg. No	0010	03521
Physicia	. n	1. Decedent's Nam	e (First, Middle,	Last)						2. Date of De		av Year	3. Time of Death
/Medic		Sandra		binson			I			1	19		3:10 P M
Examin	er	4a. Facility Name (<i>th Maple</i>		umber)			4b. City, Town, or Brunswic	Location of Death	1	1	c. County of Deat Frederic	
Funeral		5. Social Security N		. Sex	7. Age	(In yrs. la	ast birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	1		hplace (State or Foreign untry)
Director		579-94-4		1 □ M 2 🕱 F		51	Yrs.	Months Days	Hours Mill.	8. Date of Bi (Month, D	719	58 Mar	yland
land ow		Usual Residence of 10a. State	10b. County			10c. City	, Town or Loc	cation					10d. Inside City Limits
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or 28	Director	10e. Street and Nu	mber					10f. Zip Code			_	itizen of What Co	untry?
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withir jiene. r than	Completed	Elementary/Seco	ondary (0-12)	College ((1-4or 5-	+)	me. L	Baker	"			Bakery	
be filed within 72 hours after death with the Maryland tall Hygiene. vial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madical Exeminar must be notified at	BeC	17. Father's Name	(First, Middle, La	ist)					18. Mother's Nam	ne (First, Middle	, Maide	n Surname)	
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d 2 sh th and 7 is n traun		19a. Informant's N	•	_				ig Address <i>(Street)</i>					
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Pages nent o int: If i			Cremation 3 5 ☐ Other (Spe	Removal from	State			Crematory		/2010	Hag	gerstown	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine must be netified at once.		21. Signature of Fu		censee	1:			. Name and Addre					
0 5 6 0		11000	Vares A	NUL	1/1/2			hn T Willia		•		ick MD. 2	1716
Dharistan		23a. Part 1. Enter t shock, or hea Immediate Cause	art failure. List or	nly one cause on	each lin	e.	i. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	nic	a	(or as a	ı consequ	ence of):	-42 AZ	Toll				seconds
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ted sit	njue	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nmediate	Due to	(or as a	consequ	ence of):	D. co. A	ratory	Failu	10		hours
execu in and ial-trai	Examiner	that initiated events resulting in death)	5	c Due to	(or as a	consequ	ence of):	Tespi	2		1	11	. 10
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w requires that the de been signed by the should be detached	2	Part II. Other signi	ficant condition	s contributing to o	death bu	t not resu	lting in the ur	nderlying cause give	en in Part I.				the cause of death?
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he law e has ge 2 s	Completed									24a. Was auto perf		24b. Were au prior to death?	itopsy findings available completion of cause of
an: T	Be Co	25. Was case refer	red to medical						26. Place of Dea	1 ☐ Yes	-	lo 1 ☐ Yes	2 1 No
hysic his ce I direc		examiner? 1 ☐ Yes 2		Hospital: 1] Inpatier	nt 2,51	ET/Outpation	+ 3 □ DOA Oth	er: 4 □ Nursing H	ome 5 Res	idence	6 ☐ Other (Spe	cify)
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To the within To the Comple	Me	29b. Signature and	title of certifier	/7/		a'a N		29c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
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5 Stat		DR. YUN D. 31. Date filed (Mon	h M.D. oth, Day, Year)	760 il	Registra	s Signat	ure A	parks	5 200 1	CEURC	イレア	MÐ	21702
Registra	ar		JAN	2 2 2010) file	CHRAMA	J B.	The same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Patricia Ann Swindell 01/19/2010 5:47am /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Georges Prince George's Community Hospital Cheverly Prince If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** MS 1 □ M 2 🖫 F 53 9/14/1956 Director 428-06-4501 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov YSYes 2 □ No District Heights Prince Georges MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20747 USA 7013 District Heights PArkway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2KNo Baltimore, Maryland 21215-0036 "natural", or Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 12 should be filed within 7 in and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Government Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Ross Johnson Lilly Rae Beckum 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type. Print) 7013 District Heights PArkway District Heights, MD MArshall Swindell/husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC Glenwood Cemetery 01/30/2010 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Washington, DC 20011 Bianchi 814 Upshur ST NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Fatal Cardiac Arrythmia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 - Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₺ No 24a. Was an autopsy performed 2 No 1 ☐ Yes ours after death. eral Director: After this certifica filled in by the funeral director, I 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a

To the Hosp within 24 hor To the Fune completely f

31. Date filed (Month, Day, Year) JAN 2 6 2010 State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a, Certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D63688

29d. Date signed (Month, Day, Year)

01/20/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	ın/	Decedent's Name (First, Middle, Language)	ast)					2	Date of Dea Month	Day	Year	3. Time of Death
	Medic	al	Martha Seigel 4a. Facility Name (if not institution, given							anuary	22,	2010	
	Examir	ier		,			4b. City, Town, or					nty of Death	
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 😾 If Yes, Give Year or Dates.	No	If	Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexican, I	Puerto Rio	can, etc.)	В	Black, White,	etc.
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Ĕ	Page 1 ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			rt Line			1/25/	/2010	Brenty	wood,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.	7	21. Signature of Funeral Services en	isee .		22. 34	Name and Addres	s of Facility	Fort g Rd.	Lincon	Funer	ral Ho	ome
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39	endin sudin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live Birth			Ectopic pregnancy				23d. I	Date of deliv	rery
Division of Vital Records, P.O. Box 68760	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 🕱 No	4 Pregnant a			Other (specify)	y 			1	Month	Day Year
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σ <u>.</u>	es tha	by	Tart II. Other significant conditions	contributing to death b	ut not rest	alting in the ur	idenying cause give	en in Part I.					he cause of death?
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ooe	has has be 2 s	Completed							_	24a. Was ar autops perforr	y	o. Were auto prior to co death?	psy findings available empletion of cause of
ď	n: Th ficate or, pa	ပ္	25. Was case referred to medical				00.51	10 "	(0)	1 Yes 2		1 Yes	2 🗆 No
Vita	/sicia	To Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	ant 2 🗆 I	ER/Outpatient	Otho	r:		, , Hoondas
of	ig Physical (er thi	Te:	27. Manner of Death	28a. Date of injur (Month, Day	ry :	28b. Time of injury	28c. Injury	at		J. Describe ho) Hospice
on	endin eath. or: Aff he fur	fica	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	n	, rear)	liljury	M 1 🗆 V	Yes 2□N	lo				
Visi	fter director by t	Certificate:	3 Suicide 6 Could not I 4 Homicide determined		ry - At hor . (Specify)	ne, farm, stree	et, factory, office		28f	Location (Str City or Town		ber or Rura	Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 ☐ Medica! Exam	rsician: To the best of a siner: On the basis of existence of the basis of existence of the lateral section of the	camination	and/or investig	dation, in my opinior	 death occu 	irred at the	time, date and	d place, and o	due to the ca	use(s) and manner stated
	To th Within To th COMP		29b. Signature and title of certifier		_ 50. 01 1119	olouge, de	29c. License		na piace, 8		9d. Date sign		
			1 can u	angu	>		D3620)3			Januar	rv 22	2010
اد	0 10	Ì	30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type, Pr							
1			Ian Shantz, M.D.	2401 Bran	derm	ill B1	vd. Ste 2	250 G	rambı	cills,	MD 210	054	
	Stat Registra	-	JAN 2 6 2010	32. Registra	r's Signatu	are .							
					ET W								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SUPANEK **Physician** ARY 0020 M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Mandrin Chesapeake Hospice Anne Arundel Harwood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/28/1909 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 189-09-2871 1 M 2 F Min. 100 Yrs Director PA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Annapolis Director 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 930 Astern Way #307 21401 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 □Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🕱 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H Be Alex Supanek Rose Hari ပ 19a. Informant's Name/Relationship (Type. Print)
Louis Supanek/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
930 Astern Way #307 Annapolis, Md 21401 permit. Pages 1 and Department of He 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important; If it any injury or c 1 🔀 Burial Cremation 3 Removal from State Fountain Hill Cem. 1/20/2010 Fountain Hill, PA. 5 ☐ Other (Spegil 4 Donatie 21. Signatu Fuberal Service PHTLIP ACTERINALDI FUNERAL SERVICE, P.A. <u>9241 Columbia Blvd.Silver Spring,Md20910</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Speet and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner aci Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence Physician/Medical e attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year signed by the a d be detached f 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) MANDRIN Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred House 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

O. Box 68760. σ. Division of Vital Records, within 24 hours after death. To the Hospital completely

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

22 JAN

30. Name and address of person who conditeted cause of death (Item 23a) (Type Print)

MICHAEL D. La IENTH M 44 DEFENSE HIGHWAY 32 Registrar's Signature

and manner stated.

29c. License number

ANNAPOUS MO

2140/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20, 2010^a 7:30 A M Barbara Bryant Slaymaker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Casey House - Montgomery Hospice Derwood 9. Birthplace (State or Foreign Country) District of Columbia Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** March 23, 1 🗆 M 2 🔼 F Hours ar) 1936 Director 577-50-9148 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. Director 1 🗌 Yes 2 🔀 No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 United States 14702 Lindsey Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White marked other than "natural", 3 X Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ellen Smith Melvin Bryant permit. Page 1 and 2 should be Department of Health and Mer Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9112 John Simmons Street Frederick, MD. 21704 Lori Apostolico (Daughter) Date 23 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 2010 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park Rockville, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home oket 20877 10 East Deer Park Drive Gaithersburg, 23. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Imbrediate Cause (Final Approximate Interval Retween Onset and Death Physician/ disease or condition resulting in death) <u>Leukemia</u> Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown signed by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Hospice 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
JAN 2 2 2010

J. Kouertehou,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the within 2

Jocelyne Kouatchou M.D. 6001 Muncaster Mill Road Rockville, MD. 20855

1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

January 20, 2010

29c. License number

D 63 748

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep Registrar Ce	artment of Health and N		2010	03526
		H	Decedent's Name (First, Middle, Last)	timodio or Boatir	2. Date of Death	g. No. <u>2</u> U U	3. Time of Death
	Physicia Medio		Edgar Sims, Jr.		Jan. 19	, ^{Day} 2010 Year	3:05 рм
بر	Examin	er	4a. Facility Name (if not institution, give street and number) Manor Care-Potomac	4b. City, Town, or Location of Death Potomac		4c. County of Death Mon tgo	mery
	Funeral Director	ı	5. Social Security Number 225-34-0894 6. Sex 1. ★ M 2 □ F 7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yo April 12	9. Birthp (County) (**1928***) 9. Birthp (County)	lace (State or Foreign ry) rginia
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot	ocation		1	0d. Inside City Limits
	/aryla 8a-f s tified	rect	Maryland Prince George's	Hyattsville			1 ☐ Yes 2 🌁 No
	with the N 23a or 2 st be no	Funeral Director	10e. Street and Number 4110 Clagett Road	10f. Zip Code 20782	10	g. Citizen of What Coun USA	try?
	death v		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
900	urs after :ural", or al Exami	ted by	1 Never Married 2XXMarried 1X Yes 2 No If Yes, Give 1951–53	1 ☐ Yes 2 🛣 No Specify:			ite
Maryland 21215-0036	iin 72 ho ie. han "nat e Medica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16	6b. Kind of Business Ind	lustry
7	d with lygien ther ti nt, the	Be C		repreneur		Hotel/Lodgi	ng
/and	d be file fental F rked o tic eve	P	17. Father's Name (First, Middle, Last) Edgar Sims, Sr.		e (First, Middle, Mai telle Bai	,	
Mary	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rura LO Clagett Road, H			
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		TA Bando E E Ordination o E Homovai nom Otate		Date 22,	Oc. Location - City or To	
altir	permit. Page 1 Department of I Important: If it any injury or of					Bel Air, M	
m	8 9 T E 8	(2) - 7 <i>)</i>		2. Name and Address of Facility Francis J. Collins 500 University Bly			g, MD 20901
	Physician /		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Advanced Parkinso	, ,	r respiratory arrest,	·	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Advanced Parkinso Due to (or as a consequence of):	n s Disease			
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	cuted nd transit	Examiner	Cause (Disease or iinjury that initiated events c.	*			
0	ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
68760	ificate ng phy as the	Med	IF FEMALE:				
Box 6	r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 \subseteq Live Birth 2 \subseteq Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
О	that the ned by the e detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
rds,	requires t been sign should be	ted			1 🗆 Yes	2 No 3 Prob	ably 4 ¹ Unknown
Division of Vital Records,	The law re ate has be bage 2 sh	Completed			24a. Was an autopsy performe	prior to con death?	sy findings available npletion of cause of
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<u>></u>	Physer this caral dir	e: To	1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of injury 28b. Time of		me 5 Residence	ce 6 Other (Specify)	
ono	ending sath. or: Afte	ficat	Natural 5 Pending (Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No	.ca. Bosonso non	injury obodinod	
JINISI	al or Atte s after de il Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strn building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural F State)	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 is	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invess only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death of the basis of examination and/or invess only one)	tigation, in my opinion, death occurred at t	the time, date and p	place, and due to the caus	se(s) and manner stated.
	vithi To th	-	29b. Signature and title of certifier	29c. License number		. Date signed (Month, D	
	2011		P 292	D54566	J	anuary 20,	2010
			30. Name and address of person who completed cause of death (Item 23a) (Type, F Sunitha Bhogavilli, MD 9801 Georgi	rint) a Avenue, Silver S	Spring, M	ID 20902	
	Stat Registra		31. Date filed (Month, Day, Year) JAN 22 2010 32 Registrar's Signature	white			``

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State o	of Maryla		artment of I tificate of I	Health and Death		giene _{Reg. No.} 2 (010	03527	
Physicia	an/	Decedent's Name (Fire Josephine Bo		,	0			-	2. Date of Dea		Year	3. Time of Death	
Medi Exami		4a. Facility Name (if not i	institution, give	street and nun				r Location of Deat		4c. County	of Death	2:25 p M	
Funeral		Rockville Nur 5. Social Security Number	er 6. S	ex	7. Age (In yrs.	. last birthday)	Rockvil If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h	gomer 9. Birtho	I (D4-4 5 - 1	
Director		579–28–9989 Usual Residence of Dece		□ M 2 🗷 F	82	Yrs.	Months Days	Hours Min.	Nov. 2,	1927	Coun	D.C.	
/land f show ed at	tor		o. County		10c. C	City, Town or Loc	ation				1	0d. Inside City Limits	
ne Mary or 28a-	Director	Maryland 10e. Street and Number		fontgomer	у	Silver Sp	oring 10f. Zip Code			10- 04	A/b = 4 C = v =	1 Yes 2 K No	
s 23a c s 23a c lust be	Funeral	1732 Ladd St					20902	2		10g. Citizen of VUSA	what Coun	try?	
Ind 21215-0036 Filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	2 🔀 No	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - Americ ck, White, e	etc.	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed		Decedent's Econly highest gra by (0-12)			(Give k	ent's Usual Occup ind of work done ONOT use retired)	during most of wor	king		of Business Industry		
ind 2: filed wit tal Hygie ed other event, th	To Be	17. Father's Name (First,				1 11501	CICIA	18. Mother's Na	me (First, Middle,			ment.	
Marylanc 12 should be file th and Mental H 27 is marked o	-	Salvatore Bov		oe Print)		10h Mailin	a Addross /Street	Rosa Se		City on Town	Nata Zin C	No. of a little of the little	
		Silvio Stephe			band			et, Silver			state, ZIP C	ode)	
Baltimore, permit. Page 1 and 3 permit. Page 1 and 4 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Dispositi 1 Burial 2 □ Cr 4 □ Donation 5 □	remation 3 🗆 Other (Specif	y)	State	ate of He	atory or other place eaven Cemet	ery 2	Date . 26, 010		Spring,	Maryland	
Departiment of the policy of t		21. Signature Funeral	Service Licens	J-Co	le	22. F	Name and Addre rancis J. 00 Univers	ss of Facility Collins Fu Lity Blvd.	neral Home W., Silver	Inc. Spring,	MD 209	901	
Physician/ Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one value on each line. Immediate Cause (Final disease or condition Pneumonia												
Examiner					3 months								
Z pg ig	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	liate	Due to (or as a consec	quence of):							
cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last		C. Due to (or as a consec	quence of):				_			
/ 6U cate be physici s the bu	edical			d	·				<u></u>				
DIVISION OF VITAL RECORDS, P.O. BOX 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregin the past 12 month 1 ☐ Yes 2 🕱 No	hs?		Birth 2 ∟ Fei nant at time of	tal death 3 🔲	Ectopic pregnand Other (specify)	sy		23d. Dai Mo	te of delive	ery Day Year	
IS, P.O. uires that the n signed by t	by	Part II. Other significant Sarcoidosis,										e cause of death?	
VICAI KECOFGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed								24a. Was a autop perfor	med?		osy findings available npletion of cause of	
sician: certific irector,	Be	25. Was case referred to examiner? 1 Yes 2 No	1	Hospital:			Oth	ace of Death (Che					
OT V ng Phys ter this neral d	te: To	27. Manner of Death	Pending	28a. Date		28b. Time of injury	3 LJ DOA 28c. Injun	4 🗀 Nursing H	ome 5 Residence 28d. Describe ho				
DIVISION tal or Attendir rs after death. al Director: Af ed in by the fu	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐	Investigation Could not be				M 1 🗆	Yes 2 No	28f. Location (Si	broad and Musels	a a Burnel	Davita Museban	
tal or A		4 ∐ Homicide	determined	buildir	ng, etc. (Specif	fy)	ot, factory, office		City or Town		er or nurari	noute Namber,	
the Hosp hin 24 hou the Funer	Medical	(Check 2 None) 3 C	Medical Examination	ner: On the basi	is of examination	on and/or investi	gation, in my opinic eath occurred at the	e time, date and pla	at the time, date ar ice, and due to the	id place, and due cause(s) and ma	to the cau	se(s) and manner stated. ted.	
P 10		29b. Signature and time o	of certifier	Sa	IN	MD	29c. License	number 010493	2	29d. Date signed January			
		30. Name and address of John	f person who co	ompleted caus	e of death (Iter	m 23a) (Type, Pr		ville, MD 2	20854	,	,		
Sta Registra		31. Date filed (Month, Day		\$2. Re	egistrar's Sign								

			- Pleas	se Type or Prin					-		•			
			For State	State of Mar	ryland /	artment of Health and Mental Hygiene								
		Registrar 1. Decedent's Name (First, Middle, Last)						ertificate of Death				Reg. No. 2 3 5 2 8 Death 3. Time of Death		
	Physicia Medio		Willi		ott,	Jr.	Janua:	Day Year						
or himper	Examin		4a. Facility Name (if not institution, g	give street and number)			4b. City, Town, or	r Location of Death	1		County of Death			
	F	Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						Takoma Park Mon If Under 1 Year If Under 24 Hrs. 8. Date of Birth				ry place (State or Foreign		
	Funeral Director	578-70-9476 1. And the first second visiting visiting the first second visiting visiting the first second visiting visi								953 Wash	ington, DC			
	how at	٦	Usual Residence of Decedent 10a. State 10b. County		I Oc. City, To	wn or Loc	eation					10d. Inside City Limits		
	e filed within 72 hours after death with the Maryland the Hygiene. Hygiene. at other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director		George's		aurel					1 ☐ Yes 2 ☑ No			
			10e. Street and Number		10f. Zip Code 10g				g. Citizen of What Country?					
		Funeral	9033 Contee Roa		140.11	20708				United States				
9		by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.			
003		To Be Completed	3 Widowed 4 Divorced	1 ☐ Yes 2 🙀 No Specify:					Specify: Black					
15	72 ho in "nat		15. Decedent (Specify only highest	(Give I	ecedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired)				16b. Kind of Business Industry					
212	within giene. ner thai t, the N		Elementary/Seconday (0-12)		operty Manager				Federal Government					
altimore, Maryland 21215-0036	should b and Mer is mark aumatic									Surname)				
Nan			19a. Informant's Name/Relationship				g Address (Street a			-		·		
e, l	and 2 Health tem 27 other tr		Matthew A. Scot 20a. Method of Disposition	.t/son			Char Cou	irt #14	LaureI,		y Land 20 ocation - City or T			
mor	Page 1 lent of nt; If ii		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State	ceme	tery, cren	natory or other place mey Cren			l	-	Maryland		
salti	permit. Page 1 an Department of He Important: If iten any injury or oth	ľ	21. Signature of Funeral Service Lic								<u>·</u>	-		
Ω Ω	⊈∪ = @ ol		21. Signisture of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029											
L	No sision/		23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death											
	Physician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of):											
	Examiner	Examiner	Sequentially list conditions											
	e executed dian and urial-transit		If any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
			that initiated events resulting in death) Last	c. Due to (or as a c	e of):									
09	te be e hysicia he bur	dical		d										
687	to the hospital or Attentioning Priysician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	/Me	IF FEMALE:	23c, If yes, outcome of	pregnancy									
Box 68760		Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live Blith 2 Fetal death 3 Ectopic pregnancy 23d. Date 1 Ves 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 Ves 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No No No No No No No							23d. Date of deliv Month	,			
P.O.	that th ned by e detac	by Ph							23e. Did t	23e. Did tobacco use contribute to the cause of death?				
ds,	requires been sig should be	ted k	1 □ Yes 2 □ No							No 3 □ Pro	obably 4 🗆 Unknown			
Division of Vital Records,	e law re s has be ge 2 sho	Completed							24a. Was autop			psy findings available empletion of cause of		
a R	ician; The certificate rector, pag	Be Co	25. Was case referred to medical	=			26. Pl	ace of Death (Che	1 Yes		1 🗆 Yes	2 No		
VIII.	Physici this cer al direc	욘	examiner? 1 Yes 2 Mo									y)		
n of	Jing P h. After ti funera		27. Manner of Lath 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred injury work? 28d. Describe how injury occurred							occurred /				
isio	uital or Attending Physician; The k urs after death. ral Director: After this certificate ha lled in by the funeral director, page	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	farm, stre				Street and Number or Rural Route Number,						
Ď			bullaing, etc. (Specify)							Town, State)				
	To the Hospital or within 24 hours aft. To the Funeral Dir completed filled in	Medical	(Check 2 \(\sum \) Medical Exa	Physician: To the best of my aminer: On the basis of exar Nurse Practioner: To the be	mination and	l/or invest	gation, in my opinic	on, death occurred	at the time, date a	and place,	and due to the ca	luse(s) and manner stated.		
	Vittl Cor.		29b. Signature and title of certifier 29d. Dat 29d. Dat 29d. Dat						Date signed (Month, Day, Year)					
•	10		30. Name and address of person when SSI University		th (Item 23a)) (Type, P				en				
	Stat	e	31. Date filed (Month) Day Year)	ZUIU 32 Registrar's	Signature	h	e Val							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Frances Mildred Vinansky 12:45 Рм 2010 Januarv 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3705 Irongate Lane Prince George's Bowie Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year January 6, 1 🗌 M 2 🕱 F Months Hours Min. 192-24-8019 78 Scranton, PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Rowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 Irongate Lane 20715 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 🛛 No 1 ☐ Yes If Yes, Give 1 Yes 2 X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Bogus, Sr. Anna Kapcala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise V. Lattanzi / Daughter 3705 Irongate Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🖵 Cremation 3 🔲 Removal from State 2/5/2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemeterv Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue laude the Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate

Physician/ Medical

Department of H Important: If ite any injury or ot

disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transi that initiated events resulting in death) Last

Physician/Medical

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Certificate:

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10a. State

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"natural", or items 23a

if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical

death with the Maryland ms 23a or 28a-f sho must be notified at

within 72 hours after

should be

Page 1 and 2

Baltimore, Maryland 21215-0036

Interval Between Onset and Dea 10 Years Diabetes Mellitus Due to (or as a consequence of) Due to (or as a consequence of, Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 X No 1 ☐ Yes 2 L

Immediate Cause (Final

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown

23d. Date of delivery Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

28d. Describe how injury occurred

1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown

1/25/2010

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Artery Disease

Chronic Renal Insufficiency

24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of iniury 1 X Natural 5 Pending Accident
Suicide Investigation

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at work? 1 🗆 Yes 2 🗆 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 E only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

D26287

nucho 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7305 Baltimore Avenue, Suite #107, College Park, MD 20740 Michael J. Berard,

Hospital or Attending Physician: The law requires that the death certificate be executed

the

signed by t d be detach

certificate has

in 24 hours after deam. he Funeral Director: After this ce noleted filled in by the funeral dire

within 2 To the I

page

director,

Division of Vital Records, P.O. Box 68760

State Registrar

6 Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 11, 2010 Rosaria Maria Vatinno 0920 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours (Month, Day, Year) 1/30/1936 Country)
Italy 73 Director 579-68-7174 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery MD Silver Spring 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 1210 Downes Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 🕅 Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home per It. Page 1 and 2 should le filed w Degartment of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francesco Vatinno Innocenza Pacceone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soraya Rosy Fuentes/Daugh 8125 Cambourn Court Gaithersburg, Md. 20877 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. Chesapeake Crem. 11/15/2010 Beltsville, Md. 21. Signature PHILIP D. RINALDI FUNERAL SERVICE, P.A. Funeral Service 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Perforated viscus (spontaneous) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death.
Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 🗌 No Yes 2 X No 1 🗌 Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🔀 No 1 Yes ျပ 1 🔀 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗆 No Investigation the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis of examination array or investigation, in this partial, accounted at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Ashish Tolia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO.

Box

Division of Vital

29c. License number

H64588

1500 Forest Glen Rd. Silver Spring Md 20910

29d. Date signed (Month, Day, Year)

Jan. 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vincent Vallely January 2010 5:35 Medical n 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**▼** M 2 □ F July 21 New York Director 085-03-0899 1916 Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Silver Spring Prince George 15 1 🗌 Yes 2 🎦 No 0 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 20904 3160 Gracefield Road USA must h death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Force Black, White, etc. 0 þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 No Specify. If Yes. Give "natural", 3 Nidowed 4 Divorced Specify: Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Officer Treasury Department Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Page 1 and 2 should be fiment of Health and Mentalant: If item 27 is marked Catherine Fitzgerald John Spencer Vallely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10207 Lloyd Road, Potomac, MD 20854 Michael P. Vallely/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Metropolitan Crematory Jan. 2 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA of Funeral Service Licenses Francis of States of State Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death years Physician/ Alzheimer's Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death.

To the Tuneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) D24093 Jan. 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Mark Parkhurst, MD

State

Registrar

31. Date filed (Month, Day, Year) JAN 22

2010

Scholin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Addie Lee Watkins 7:15 °M /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6213 Glen Dale Rd. Glenn Dale Prince Georges 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. I Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 83 Days Hours Year 1 □ M 2 🖔 F 578-42-2701 Director 08-20-1926 Wilson. Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show DC Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3978 East Capitol St. NE 20019 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes X No Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filled wi thrent of Health and Mental Hygier tant: If item 27 is marked other th ijury or other traumatic event, Inc. Manager Walter Reed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wright Creech Sally Barnes ဥ 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code)
1611 Varnum Pl. NE Washington DC 20017 19a. Informant's Name/Relationship (Type. Print) Eunice Finch- Daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If a Harmony Memorial Pk 1/30/2010 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 Koons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinct, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical aftending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been s page 2 should Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: ည 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural Injury 5 Pending investigation 1 □Yes 2 □ No 2 Accident illed in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year)

CR 6

State 31. Da Registrar

31. Date filed (Month, Day, Year)

Jd Birminghorn 32 Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Irving St. NW. Wash.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 s 2010 Physician/ Month Jan. 0130 М <u>Leo Watkins</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Center Anne Arundel Medical 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 25, 1943 9. Birthplace (State or Foreign Social Security Number **Funeral** Arkansas Months Days Hours Min. 1 🖾 M 2 🗆 F Yrs 550-56-3914 Director Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f shov 10a. State 10h County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Bowie Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code Funeral 20716 United States 2810 Nomad Court West items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 0. 1 Never Married 2 Married þ e filed within ...
antal Hygiene.
--ther than "natural", o Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Mechanic marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental be file of Health and Mental befitem 27 is marked o 2 Thelma Howard John Watkins Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2810 Nomad Court West Bowie, Maryland Leo Watkins Jr./ Son 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, Department of Important: If it any injury or o ooce. þ 1 Burial 2 X Cremation 3 Removal from State Lee's Crematory 1/29/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service 20019 4001 Benning Rd. NE Washington, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month 4 ☐ Pregnant at time of death g ☐ Unknown 2 🗌 No the detached 9 Unknown P.O. cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate I 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. work?
1 Yes 2 No 1 Natural 5 Pending after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Certifying Priystrain: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

State

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29c. License numbe

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death narice Day, Physician/ Month Alexander 28 19:00 M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death St. Mary's Hospital Mary's Leonardtown 5. Social Security Number 410–64–3547 . Age (In yrs. last birthday) 85 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MS **Funeral** Days 1 🕅 M 2 🗆 F Months Hours Min Director Usual Residence of Decedent 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director Charlotte Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20622 29449 Charlotte Hall Rd Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 XXes 2 □ No Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2XX No Specify: If Yes, Give Completed **¾**Widowed 4 ☐ Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical) 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Air Force Senior Master Sargent 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jones Willie G. Alexander ^{19a.} Informant's Name/Relationship (Type, Print)
Sheryl Hicks /Granddaughter 19b Mailing Address Street and Number or Rural Route Number, City, or Toyo, State, Zip Code) PO Box 7598 Upper Mar Lboro MD 20792. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Argentary, Charactery of other place) 02/1/2010 Hanover Maryland Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Victor Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 كتاتك 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final standsti Physician/ Ventricular disease or condition resulting in death) ninutes Medical Due to (or as a consequence of): Examiner Cardiopulmonary Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Alexander 24a, Was an autopsy performe Be Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 유 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d, Date signed (Month, Dav. Year) 00038847 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.0. Box 524 Leonardtown, MD Hospital Stmarys 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Constance L. Ashton 23145 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner tal re Hospi Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Days Hours Min. MArch22, 378 m 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 2^{Year} 194 1 □ M 2 🔀 F 216-38-3556 68 Yrs. MD Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the INV digal Examinant out the rectified at Director MD Baltimore Essex 1 ☐ Yes 2 ☐ XSo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 446 Stemmers Run Road 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HArold Marvin Ruth Ann Crouse ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Ashton / husband 446 Stemmers Run Road Baltimore MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Crematory Bayvijew 2/15/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner trus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed urren e C and burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 sl 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Medical Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. Division of Vital Records,

Nton

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

State

29b. Signature and title of certifier

FEB 1 6 2010

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

KES00000

02-14-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thoma Selena 9000 Frankl 31. Date filed (Month, Day, Year) 32. Registrar's Signature

29a, Certifier (Check only one) Frances M. Adams Baltimore, Maryland 21215-0036

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinar must be notified at any injury or other traumatic event, Ite Madical Examinar must be notified at any once.

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1 - State Registrar				C	ertificate of	Death	R	eg. No2 ()	10	0353	
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	4a. Facility Name (If not ins	titution, giv	e street and n	umber)		4b. City, Town,	or Location of Death		4c. County	of Death		
	Good Samaritan Hospital					Baltimo		N/A				
	5. Social Security Number 6. Sex 7. Age (In yrs. last birth					Months Davs		8. Date of Birth 9. Birthplace (State of Country)			ace (State or For	
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	10 College (1-46/ 5+)					HAIR SALO	N		SELF	EMPL	OYED	
	17. Father's Name (First, Middle, Last)						18. Mother's Name	e (First, Middle, N	laiden Surnan	ne)		
-	AUGUST LIGU					MARY (CHIMELLI					
Ī	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										Code)	
	JOSEPH DeMUN	, SR	- SON		54	02 HILLBU	RN AVENUE	BALTTMOI	RE. MD	21214		
I	20a. Method of Disposition			2	20b. Place of Dis	sposition (Name of			20c. Location -		n, State	
	1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State		rematory or other pla DEEMER CE		/2010 I	BALTIMO	RE. M	ARYLAND	
ŀ	21. Signature of Funeral Se					22. Name and Addr				-		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 5402 HILLBURN AVENUE BALTIMORE, MD 21214											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year awar tebrucon 26 Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memoria TTOSF on Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Yrs. **Director** (avoline Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a 506 212 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, et ö þ 1 \square Never Married 2 \square Married Maryland 21215-0036 1 ☐ Yes Mo Specify "natural", Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation ify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 alth and Mental Hygiene.
127 is marked other than "I traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) as 0+6 Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ 10 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Gremation 3 Removal from State 5 🗆 Other (Specify) 21. Signature Funeral Service/License 21229 of the disease, or complications that caused the death. Do not enter the make of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Couse (Final disease of condition Physician/ 200000 indestinal Medical resulting in death) Due to (or as a consequence of): Examiner Per toro Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and -tran Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 \square Yes 2 \nearrow No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed has page certificate 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certification completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 - Pending iniury work? 2 \square No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature, and title of certifier - 2438946 XI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vesit

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.0.

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 03538 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 12,2010 8:15 a /Medical Helen Arndt 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 36 Mardrew Road Baltimore n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2🂢 F 90 Director 219-07-8875 4/22/1919 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov 1 Yes 2 □ No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36 Mardrew Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Completed by 3 XWidowed 4 ☐ Divorced "natural" White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cable Lacer 8 Mfq. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fight and Mental F Compton I. DuVal, Sr. Maryellen McCann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Pages 1 and 2 ment of Health a ant: If item 27 Is Eleanor E. Miller / Sister 36 Mardrew Road, Baltimore, Maryland 21229 Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Bayview Crematory 2/15/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final F. Blosis **Physician** ISIODATHIZ 106 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any least grain in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a honsequence of) The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of) physician by Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy or Day Month Year 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No EDATIC 4575 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 5 Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

State Registrar

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

DHMH 17 Rev 1/2001

3449 WIKENS

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHITTY

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 630 Delores E. Bailey EBRUAR Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death tospital of Balto Himore m'8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 216-24-6431 Hours Min. (Month, Day, Year) 06 03 29 Director 80 MD Usual Residence of Decedent Fshow 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 23a or 28a-f MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 2522 Cylburn Ave "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black White etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. the Medical Known as Delores 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Operator A.T.T. 12th Grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wilson Marqurite Willis permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prenterald Price-Son 104 Kauffman Road, Parkton, Md 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 2/18/10 Woodlawn, Md Woodlawn 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licens 22. Name and Address of Facility

Aarch F/H West

4300 Wabash Ave, Baltimore, 23a. Part 1/ Enter the disease, or complications that shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caus Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the hural. Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an After this certificate has page 2 performed 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TUNG မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation thin 24 hours after death the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 0 29d. Date signed (Month, Day, Year) 2 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Date filed (Month, Day, Year)

FEB 16 201

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03540 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Brown** Gladys E. Physician/ Month 1:02am M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Clinton MD 4c. County of Death
Prince Georges Examiner Southern Maryland Hospital Center 7. Age (In yrs. last birthday) 84 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign 157-22-4295 Days Hours 1 🕱 M 2 🗆 F 7/17/1925 Director GA Usual Residence of Decedent or 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Early Blakely 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39823 7744 Cedar Springs Road USA 12. Was Decedent Ever in U.S. IB. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Completed 3XXWidowed 4 ☐ Divorced Specify Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Ceaser 9 Eugene Mcintosh 19a. Informant's Name/Relationship (Type, Print)
Brenda Brown / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2723 Lorring Dr., Apt 102 Forestville MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Green Cemetery or other place) 1 Burial 2 Cremation 3 X Removal from State 1/30/2010 Blakely, 4 ☐ Donation 5 ☐ Other (Specify) Sig Wroof Function bervice License Victor P. Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Exami To the Hospital or Attending Physician: The law requires that the death certificate be execoted within 34 hours after death Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has ballinector, page 2 s autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 9 Other: 1 🗌 Yes 1. Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 24 hours after death.
Funeral Director: After ited filled in by the funeral 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-22-2012

State Registrar 31. Date filed (Month, Day, Year)

M.C

32. Registrar's Signature

ng Sten Rd #10/ft ingthistan MO 2076

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Angelica Bartlett Month 12:25am Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Sunrise Assisted Living Bethesda 5. Social Security Numbe 161–48–1686 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**XX** Hours Min. Months (Month, Day, Year) 12/11/1912 96 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PA Allegheny Pittsburgh 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country 6946 Blenheim Ct Funeral 15208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 XNo Specify: white 3 ★ Widowed 4 □ Divorced Completed Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Joseph Restivo Gaetana Curione 19a. Informant's Name/Relationship (Type, Print)

Josepha Faley / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Primrose Street, Chevy Chase MD 20815 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Homewood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/17/2010 Pittsburgh, 4 Donation 5 Other (Specify) of Coneral Service Licensee Victor P. 22. Name and Address of Facility
L. Stevens Funeral
1501 E. Fort Ave, Baltimore Doda CI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial **Medical** Box 68760 E FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death Yes 2 K No 9 Unknown 9 Unknown Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate has 1 Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 2 **XX**No within 24 hours are wow.

To the Funeral Director: After this of the funeral filled in by the funeral dir ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this **Living** 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1XXNatural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D55258 2/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6340 Rockledge Drive, Suite 470, Bethesda MD 20187 Wilks, MD

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

FER 16

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name *(First, Middle, Last)* Anna Balsiunas 2. Date of Death M27/3/2010 Physician/ Year 12:40amM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing and Rehab. Montgomery Rockville Maryland cial Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 034- 22- 3881 Months 1 D M 2 X F Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. MA Worcester Worcester 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Mary Scano Drive 01605 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. white 3 Widowed 4 Divorced Specify Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last)
Adam Balsiunas 18. Mother's Name (First, Middle, Maiden Surname) 2 Nellie Barauskas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eleanor Duvall/Niece 1112 Post House Ct. Potomac Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXXvirial 2 Cremation 3 Removal from State Hope Cemetery 2/13/2010 Worcester, MA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor P. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore Maryland21230 Doda, Jr XC5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any leading to in necial cause. Enter Underlying Examiner burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No been signed by the atte should be detached for 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performed? After this certificate 25. Was case referred to medical Hospital or Attending Physician: completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 🗶 No ೨ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Af Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a, Certifie 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar YAO

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Boalman Month Day Physician/ JOHA 30 AM 20110 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anno Amade 296 Halsey Road Annapolis 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 M 2 □ F Days Hours Min South Dakota Director 93 143-16-0767 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🏿 Yes 2 🗆 No Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 296 Halsey Road 21401 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Conway Boatman Caroline Brasher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. 296 Halsey Road, Annapolis, MD 21401 Janet Boatman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 02/15/2010 Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licer 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonitie Physician, 1 month disease or condition Medical resulting in death) Due to (or as a o Examiner Univor mantin Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying 6mac Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No g 🗌 Unknown been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tea everative soint disease 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Were autopsy findings available prior to completion of cause of 24a. Was an page death? this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: 2 1 No Other: 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Af Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical l 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2/20/6 mpleted cause of death (Item 23a) The Sivien, MD 30. Name and address of person They lone Sut 705 land MD 31. Date filed (Month, Day, Year) 32. egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

				State of Maryla				•		03544
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	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	AKA) JOSEP		BRAUN		2. Date of Deat Month		3. Time of Death
	Medic	cal	4a. Facility Name (if not institution, give str	A Dra	Lun	T # 01 T		2	6 2010	300 (4 M)
	Examin	ier	OAKCREST VILLAG	E		PARKVI		1	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 9 1 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M 2 x F 7. Age (In yrs. 9 2	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birth (Month, Day, 0 3 / 1 9		rthplace (State or Foreign ountry) ERMANY
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	vlaryla 28a-f s tiffied	rect	MD BALTIM	ORE	ROSEDA	ALE				1 ☐ Yes 2 🟋No
	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number		_	10f. Zip Code		1	l0g. Citizen of What Co	ountry?
		nner	8419 COCO ROAD	2. Was Decedent Ever in U	Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp			pecify Yes or No-	USA 14. Race - Ame	avigan Indian
21215-0036		þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			Black, Whit	te, etc.
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	and 2 shou Health and tem 27 is m		WOLFGANG HERDECH			ng Address (Street &		1	City or Town, State, Zi	,
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Re	20b.	Place of Dispo	osition (Name of matory or other plac			20c. Location - City or	
tim	permit. Page 1 Department of Important: If i any injury or once.		4 Donation 5 Other (Specify)		TRO CE	REMATORY	₩ 02/	09/10	BALTIMOR	
Bal	permi Depar Impol any ir		21. Signature of Funeral Service Licensee							ERAL HOME
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consec	quence of):	DI				
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	be executed sician and burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):					
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. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 bours after death. within 24 bours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnanc Other (specify)	y		23d. Date of de Month	elivery Day Year
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of Vi	g Physical this care direction	e: 10	1 Yes 2 No Post	1 Inpatient 2 28a. Date of injury	28b. Time of	nt 3 ∐ DOA	4 Nursing H	ome 5 Reside	nce 6 Other (Spec	:ify)
ouo	ending sath. or: Afte he fune	ficat	1 Accident 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work'		2541 25551125 115	Wingary Coodings	
Division of Vital Records,	ital or Atturs after de ral Directorilled in by t	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Town		
:	e Hosp 124 ho e Fune	Medical	(Check 2 Medical Examiner	an: To the best of my know : On the basis of examination Practioner: To the best of m	on and/or invest	tigation, in my opinio	n, death occurred a	at the time, date and	d place, and due to the	cause(s) and manner stated,
	To the comp		29b. Signature and title of certilier		w		number		9d. Date signed (Month	
	81		30. Name and address of person who com	pleted cause of death (Ita	m 23a) (Type, P	Print)	the A	121 20	Marle	Md 20234
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2/10/10 315am Braun, Josephina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03545 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harvey Pettibone Barnard, Jr. Month 20 10 3:05 A Februar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Sept. 19, Funeral 9. Birthplace (State or Foreign 1 😾 M 2 🗆 Months Hours Pennsylvania Director 061-12-7689 96 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Silver Spring Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2201 Colston Dr. 20910 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or i Black, White, etc. þ 1 Never Married 2 X Married Yes, Give 2 🗌 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural" 3 Divorced WW II Completed Year or Dates. the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Executive Airline Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvery Pettibone Barnard Helen Hastings traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann B. Barnard / Wife 2201 Colston Dr., Silver Spring, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 🗌 Burial 2 🏋 remation 3 🗌 Removal from State Chesapeake Crematory 2/10/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 Supley Johnson tha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Weeks Medical Due to (or as a consequence of): Examiner End Stage Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed for use as the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ed by the a a 🗌 Unknown 9 Unknown the Hospital or Attending Physician: The law requires that the signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure, Atrial Fibrillation Division of Vital Records, 1 2 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Hypertension has autopsy certificate 2 240 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Barbaro D 0065485 Suparuch RSM. MD

Registrar

State

Barbara Supanich, RSM, M.D., 1500 Forest Glen Rd., Silver Spring, MD

20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Examiner S If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**№**M 2□F 96 Yrs Director 215-01-7814 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at JOPPA HARFORD MD Director 10e Street and Number 10f. Zip Code 21085 602 WINESAP COURT Brockmey or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or iter may injury or other traumatic event; the Medical Examiner and. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 17. Father's Name (First, Middle, Last) Maryland Be BROCKMEYER AUGUSTA ANDREW Η. ပ 19a. Informant's Name/Relationship (Type. Print) 602 WINESAP COURT LOIS J. SMITH/DAUGHTER Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State 2-17-10 GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee T211 CHESACO AVE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Ö detached 9 Unknown 9 ☐ Unknown by signed t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by page 2 s certificate has Vital 25. Was case referred to me ical examiner? director Be 1 ☐ Yes / 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 0 this funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 00 PM February ANDREW BROCKMEYER JOHN 2010 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) MARYLAND 12-10-1913 10d, Inside City Limits 1 ☐ Yes 2 ☐ No 10g, Citizen of What Country? U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry CONTINENTIAL CAN 18. Mother's Name (First, Middle, Maiden Surname) (AMEREIHN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOPPA, MD 21085 20c. Location - City or Town, State BALTIMORE, MD 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21237 ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 → 10 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 26. Place of Death (Check only one) Other: 4 Desire Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cance of death (Item 23a) (Type, Print) 110 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

State Registrar

Physician

/Medical

10-01073	
Dina Butler	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Dina Lynn Butler **Medical Examiner** 0754 hrs February 6, 2010 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Salisbury Penninsula Regional Medical Center Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days -40-9997 Hours Min Director 2^X F 47 12/02/1962 DE 1 M Country) Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once, 1 Yes 2 X No MD Wicomico Salisbury hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7948 Naas Road 21801 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc 1 X Never Married 2 Married 2X No Yes White f Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Divorced Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed mit. Pages I and 2 should be filed within 72 hou partnern of Health and Mental Hygiene. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Waitress 1 Food Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Julian Leonard Butler, Jr. Be Theresa Sant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian L. Butler, Jr., Father 339 Lee Thee Church Road, Rockingham, NC 28379 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Atlantic Crematory 02/13/2010 Glen Burnie, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility Carter Funeral Home 21. Signatur ... f F | eral Service L' ... T. Harman 705 Caroline Street, Rockingham, NC 28379 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and Physician/Medical AMENDED #5, per Fh g901 3/8/10 TT 23a,27,permE, g901 3/8/10 g physician g the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth has been signed by the attending: 2 should be detached for use as t 3 Ectopic pregnancy Fetal death Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other₄ Hospital: 1 Inpatient this 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No hours after death. Director: Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) (Specify) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 8, 2010 30. If me and address of person who complete cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Marie By, Year State 32. Ragistrar's Signature Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 35 M Feb mond 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/24/1967 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 X M 2 □ F Yrs. 43 Director 213-86-2317 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hyglene. and the filed and 27 is marked other than "natural", or items 23a or 28a-3 show any or other traumatic event, the Mades Examiner must be refitted at Iny or other traumatic event, the Mades Examiner must be refitted at 1 ☐ Yes 2 XNo Director MD Baltimore Co. Windsor Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7903 Subet Road 21244 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify: Black 1 ☐Yes 2X No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Handyman Self employed altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Redmond E. Thomasine Lee Robertson ၉ Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Barnes(Sister) 7903 Subet Road, Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place)
JOSEPH BROWN F/H
And Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit the death certificate be executed Exami Due to (or as a consequence of) physician the burial P.O. Box 68760 Physician/Medical attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day i signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 HInknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Inknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2**X**No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 6 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BCB 21 27 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03549 State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 7, 2010 **Physician** Stephen Jeffrey Britt 5:50 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗶 M 2 🗆 F Months Days Hours Min 218-68-1111 Jan. 25, 1955 Virginia **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10a. State Frankford Delaware Sussex 1 □Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19945 34974 Bennett Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗶 No Specify Completed by Specify: White Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced and 2 should be filed within 72 ho leatth and Mental Hygiene. m 27 is marked other than "natur her traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine C. Miller Cecil A. Britt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Britt/ Wife 34974 Bennett Road Frankford, Delaware 19945 20c. Location - City or Town, State Pages 1 (ment of H 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 13.permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2010 Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Alice Iser 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) MYOCARD IAL FW MINS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Phospital or Attending P 24 hours after death. Funeral Director: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 32. Regi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ Month 02 Burden-White Lorraine 9:30p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritchie Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Months Days 1 M 2 F 06-21-1966 Maryland Director 213-84-5938 43 Yrs. Usual Residence of Decedent 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 2418 E. Oliver Street 21213 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify. 3 Divorced Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry na. Decedents obsul occupation (Give kind of work done during most of working life. DO NOT use retired) MEditeatrectords (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 2years Wyman Park Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Moses Burden Christine Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2418 E. Oliver St., Baltimore, MD 21216 Torrence A. White Sr.(son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Carmel Cem. 02/20/10 Baltimore, MD permit. 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 13 HEATS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list on difficult, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Vear Day 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, conce 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 12entension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 ☐ No Yes 2 No of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 to ther (Specify) 2 1 No nospice 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death

To the Funeral Director: After

C

State Registrar

only one)

29b. Signature and tale of

31. Date filed (Month, Day, Year)

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo

300

Règistrar's Signature

Aertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

056211

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 O 7 20^{Year} **Physician** 10:00p^M George Bennett Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 733 Yale Avenue 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day. 5. Social Security Number **Funeral** Hours Min 1 XM 2 ☐ F 07-13-1933 76 Director 215-32-9113 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examinat must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ty Yes 2 No Funeral Director Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 U.S.A. 733 Yale Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Be Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Spring Grove Elementary/Secondary (0-12) College (1-4or 5+) Hospital Cook 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bennett Sr. N/A George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne E. Bennett(Wife) 733 Yale Ave., Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 02/23/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., BAltimore, MD 21216 nuc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic 2years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or ea a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 16a, b, perFH, G900, 2/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03 Butler James 07 Willie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Pikesville Courtland Gardens Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/11/1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 6. Sex 1 **X**M 2 □ F Months Days Hours Min. S.Carolina Director 214-20-4636 82 Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Windsor Mill Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: I filem 27.1 marked other than "naturat", or Items 23a or 1 mortant in fully 10 than 10 mortant in India 20 or 30 or 10 mortant in India 20 or 10 marked other than "naturat", or Items 23a or 30 or 30 mortant in India 20 or 30 or 21244 U.S.A. 8005 Woodgate Apt. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Army Chef Chef Chof U.S. Army 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Butler Mary Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8005 Woodgate Apt A, Windsor Mill, MD 21224 Butler(Wife) Hilda 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat'L 02/19/10 |Baltimore City ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner onar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequente of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy Month Day 5 ☐ Other (specify) been signed by the same should be detached it Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown cate has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 ☐ Yes 2 ☐ No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26 Place of Death (Check only one) Other: 1 ☐ Yes Medical Certification: To 1 🗀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury 27. Manner of D 4th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Vatural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scotts level Nel Bathmore MAP 1alon 1920 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03553 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sallie 02-07-2010 Mae Bussey 4:30p M Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Co. 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏞 F 0 3 - 2 4 - 1 9 5 1 Months Days Hours Min. Director 58 Johnston, S.C 577-72-7243 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD P.G. Hyattsville 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 2400 Queens Chapel Rd., #611 20782 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force 1 X Never Married 2 ☐ Married Black, White, etc. ☐ Yes 2 XNo Completed by Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dental Hygienist Howard University H. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bussey, Sr. Howard Lizzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 of Health a item 27 i Page 1 and 2 Mary F. Welch - Sister 2400 Queens Chapel Rd., #611 Hyattsville, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 02-18-2010 Landover, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ronald Taylor II Funeral Hm 10583 Middleport Lane, White Plains, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Advanced Multiple Sclerosis Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery ō in the past 12 months? Month Pregnant at time of death Day Year ed by the a Yes 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed certificate 1 Yes 2 XNo 1 Yes 2 No after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Katural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (0 D66372 February 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Majid Rahmanianshahri

31. Date filed (Month, Day, Year)

FEB 16 2010

- 1500 Forest Glen Rd. Silver Spring, Md. 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03554 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BOBBIE LOUISE BARE 11:28 A.M Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL BALTIMORE TOWSON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 V F 11-2-1928 410-42-0510 81 Chuntry) **Director** Usual Residence of Decedent show 10a. State 10b County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Marvland Baltimore Baltimore County 1 Tes 2 X No 10e. Street and Number ō 10f. Zip Code "natural", or items 23a o 10g. Citizen of What Country? within 72 hours after death with Funeral 43 Fullerton Heights Avenue 21236 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married X Married 1 ☐ Yes 🗶 🗘 No If Yes, Give Maryland 21215-0036 1 ☐ Yes ½ X No Specify: Specify: White Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) 12 Yrs Homemaking ~ Own Home Homemaker Be 17. Father's Name (First, Middle, Last) it. Page 1 and 2 should be filed rtment of Health and Mental H rtant: If item 27 is marked oth njury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ျ William C. Ross Grace M. Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Rudd C. Bare 43 Fullerton Heights Avenue Nottingham, Md. 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2-15-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home 7401 Belair Rd. Balt Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ holangiocarcinomo disease or condition resulting in death) Medical Due to (or as a conse nce of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Liter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🗶 No Month Dav Vear 1 ☐ Yes 2 ☑ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 Yes 2 No **Director:** After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 L Yes 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a To the Funeral I Medical 29a, Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number W 3182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's

7601 Osler Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 4:50 A MM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death House 95cx ROCKVIlle Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 578-30-67-3 1 🗆 M 2 🗀 F Director amobell co Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County Funeral Director 10d. Inside City Limits 1 🗓 Yes 2 🗆 No Montgomer 10e. Street and Number # 10f. Zip Code 10g. Citizen of What Country? 20 5 20 U. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Black Afficen American Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) brarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam 2 Nice e) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Park Lak lasmin Hollowar uanna MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 02-12-2010 4 Donation 5 Other (Specify) (rematery iverdale 21. Signature of Funeral Service Licensee Name and Address of Facility 4804 AV Georgia timeral Home - moi182 20011 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Congestive Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence oi). Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No g Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl performed? Yes 2 X No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Casey House ပ္ 1 🗌 Yes 2 🛚 No Other: this 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending 2 \square No neral Director: A Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 General registration of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 General registration of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Doo 60634

Registrar

State

31. Date filed (Month, Day,

rar's Signatur

1355 Piccord Drive Suite 100 Rockviller MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13.55 Piccord

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ALICE BEAULIEU 17.45 2010 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ARUN DEL GLEN BURNIE HEALTH AND REHABILITATION CENTER GLEN BURNIE ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1□M 21□F 226-32-6412 80 Feb.27,1929 VA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Kent Road 21060 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖾 No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Services Representative C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harrison White Shumaker Alice Jameson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr George A. Beaulieu/Husband 400 Kent Road Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 23, 2010 Maryland Vets. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW GLen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER WITH METASTASIS Due to (or as a consequence of): META BOLIL ENCEPHALO PATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): HYPERCALCEMIA Due to (or as a consequence of): Physician/Medical CORONARY ARTERY DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🗵 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ∐ Yes 2 K No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗷 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Many 02/15/2010 D0058580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

State Registrar

Funeral

Director

28a-f show

"natural", or items 23a

injury or other traumatic event, the Micical Exeminer roust be rediffed at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event size.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) FEB 16 2010 32. Registrar's Signature

Kanu, MD. 3233 SUPERIOA LN, B21. BOWIE, MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Α. Beckwith-Renoff /Medical **February** 13, 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Meadows Baltimore Glen Arm 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Min. 1 □ M 2 🗓 F Days Hours Director 215-16-6812 Aug 22, 1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, The Medical Experiment and Experiment once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 11630 Glen Arm Road, unit AL251 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 🕅 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Teacher Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles Anderson Ruth Barnard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Glenangus Drive, Bel Air, Maryland Mark A. Beckwith/Son 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2/15/10 Glen Burnie, Maryland rune of Funeral Service Lice of Service Lice o 22. Name and Address of Facility

Physician /Medical **Examiner**

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Physician/Medical

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After this

within 24 hours after death

To the Funeral Director:
completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immedi e Cause (F) al disease y condition resulting in

Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death ARDI Due to (or as a consequence of): ORONAR Due to for as a consequence of HERO SCL Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant

1 ☐ Yes 2 X No

9 Unknown

in the past 12 months?

23c.	lf	yes,	ou	tcom	ne o	of pr	egna	and	y
	1		ve	birth	- 1	2 🗀	Feta	ıl d	eath
	4	ПР	rea	nant	at	time	of o	do:	ath

9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

26. Place of Dea

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

KAMANA oddress of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

2 No 3 Probably 4 Unknown 1 Tes 24a. Was an

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

PONA

	1 🗆 Yes	2 XN
th (Check only	one)

autopsy

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

examiner? 1 ☐ Yes	
27. Manner of	□Pendir

5 ☐ Pending investigation

6 □ Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \(\sum \) Nursing Home 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 ☐ Other (Specify)

29a.	Certifier
	(Check on
	one)

2 Accident 3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 210

State Registrar AMAMA GOPAL 31. Date filed (Month, Day, FEB 1 6 2010

32. Registrar's Signature

KOLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g900 2-16-10 vt. State of Maryland / Department of Health and Mental Hygiene For
 State
 Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Fe bruosy 10:50 PM **Physician** 12 2010 Lois Marie Barrett /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner St Agnes Huspitel Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 16, 1 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. 1 □ M 2 🗗 F Days Hours 578-34-7863 80 1929 Washington D.C Director Oct. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "fedical Examinet must be redified at MD Montgomery Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 North Leisure World Blvd Apt 227 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. SpecifWhite Completed by 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Defense Secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any Injury or other traumatic event other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter B. Powell Ouinty I. Parrott 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 Greenlow Road; Catonsville, MD 21228 Robert Barrett Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20 2/19/2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park Rockville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21 Signature of Funeral Service License Quelle 23a. Part1. Enter the disease, or complications that cause the death or not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD **Physician** /Medical Due to (or as a consequence of): Examiner Atrial Sequentially list conditions, and the sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence neumoria the death certificate be executed signed by the attending physician and i be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes of Vital Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 24069 $\omega_{\mathfrak{D}}$ 12 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HLAING TINT: 900 Carton Ave; Baltimore, MD 21229 Cator TINT : 900 31. Date filed (Month, Day, Year) State Registrar anna

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			1 - For State Registrar	State of Maryland		rtment of F tificate of		Mental H	ygiehe Reg. No.		
	Physic /Medi		1. Decedent's Name (First, Middle, Last,	Beine				2. Date of D Month	3	2010	3. Time of Death 69:30 Am
	Exami Funeral Director	ner	4a. Facility Name (If not institution, give Greater Baltimore 5. Social Security Number 116-16-1281 6. Security Number	Hedical Cent	ast birthday)		Location of Death USON If Under 24 Hrs. Hours Min.	0.0-1		Balty 9. Birthp County	lace (State or Foreigr stry)
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36	7.72 hours after death with the Maryland "natural", or iteme 23a or 28a-f show callest Examinar must be notified at	by Funeral [1 Never Married 2 Married	12. Was Decedent Ever in U.: Amed Forces? 1 ™Yes 2 □ No If Yes, Give	If	1	212 lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	1	an Indian, etc. white	
Maryland 21215-0036	- 100	Completed b	3	Year or Dates:	16a. Deced (Give)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) DESSOT			Specify: WILL'E 16b. Kind of Business/Industry University of Baltima		
yland 2	D D D	To Be C	17. Father's Name (First, Middle, Last) Francis Foulke Beirne 18. Mother's Name (First, Middle, Maiden Sumame) Rosamond Randall								
	olth 27 is		19a. Informant's Name/Relationship (Ty Priscilla Beirne-s							ity or Town, State, Zip Code) Jaryland 21212	
Baltimore,	Pages nent or ant: if i		20a. Method of Disposition 1 Burial 2 Cremation 3 A 4 Donation 5 Other (Specify)	emoval from State Drui	d Ridg	ition (Name of atory or other place e Cemete	ry Feb.	Date 13,2010		cation - City or To Limore, Ma	
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	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line. Due to (or as a consequ					arrest,		Approximate Interval Between Onset and Death
	cate be executed by physician and it is the burial-transit and	Examiner	St. uential y list conditions and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	eary a	unia rtery d	liscas	•	- 1	6 month 0 years
P.O. Box 68760	death certifi e attending id for use as	Physician/Medical I	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□I ath 5□	Ectopic pregnancy Other (specify)			2	23d. Date of delive Month	ry Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	۵	Part II. Other significant conditions con Chronic myelog red cell apla	renous leuk	Iting in the un	derlying cause give	en in Part I.		e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
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Division of Vi	ding Phys h. After this funeral di	Certification; To Bo	examiner?	ospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify,	28b. Time of Injury	28c. Injun Work M 1 🗆	4 Nursing H	ome 5 ☐ Res 28d. Describe 28f. Location	how injury	l Number or Rural	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	ledical Cer	29a. Certifier 1 Certifying Phys	ician: To the best of my know er: On the basis of examinati	vledge death	occurred at the timestigation, in my op	ne, date and place pinion, death occu	and due to the	cause(s);	and manner as st	ated, the cause(s)
)	To the Youthin 2 To the Comple	Mec	29b. Signature and the of certifier	and manner stated.		29c. License	number 34193		29d. Date	signed (Month, I	Day, Year)
			30. Name and address of person, the co			rint) Luthi	eville,	MP	2109	23	
S DHI	Sta Registr MH 17 Rev 1/2	ar	31. Date liled (Month, Day, Year) FEB 1 6 2010	32 Registrar's Signatu	fa	No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:10 PM ex 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) Wes ster General Count If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year Social Security Number Funeral Year) Months Min. Days Hours 1 X M 2 □ F 217-46manuanc Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number CX Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ≥ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 3 2 should be filed within 7 is and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Haministrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is ready injury or other 19a. Informant's Name/Relationship (Type. Print) 200 Kesh Mil MD210 Hampstead itricia 20b. Place of Disposition (Name of cemetery, crematory or other place)

Example Transcruter Translit.

Tematics Services - Cetair Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 2/16 62010 torest Hill 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services - Monkton
11624 York Road, mankton Manyland 2/11/1 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cordiaic. arr Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner J 20423 es After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): 7204rs Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed' 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No spital or Attendl nours after death. neral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinary On the basis of examination and/or investigation in the second discontinuous data. 29a. Certifier Medical ExaminaryOn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check or one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur 53902 February 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip Fi MAC, MD, 1447 YOOK Rd, hufliewitte, MD 31. Date filed (Month Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** 2010 0630 AM MMA /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NURSING BALTIMORE HOM Year If Under 24 Mr Days House OCH 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 9. Birnplace (State or Fore (Month, Day, Year)

December 19, 1923 Delmar, Delaware Months Days Min. 1 M % TXF 86 216-24-1659 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County Maryland Baltimore Parkville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States 9210 Orbitan Road 21234 America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk. Helen White ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9210 Orbitan Road Parkville, Maryland 21234 Mr. Richard L. Butler/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 19, 2010 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Fymeral Service License 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 48 HRS disease or condition resulting in death) RESFIRATORY DEPRESSION /Medical Due to (or as a consequence of) Examiner STAGE DEMENTIA 2 yrs NO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): eq Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown DYSPHAGIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No Director: 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide NURSE PRACTITIONER

Division or Vital Records, P.O. Box 68760 within 24 hours a To the Funeral

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRANT

312

32. Registrar's Signature

CHICKORY

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WRY

29c. License number

L1-0017

NEWARK

29d. Date signed (Month, Day, Year)

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	Medi	cal	Marylouis 4a. Facility Name (if			umborl.					Feb1				0	5:32P. M
1	Stella Maris 5. Social Security Number 6. Sex					7. Age (In yrs. last birthday)			4b. City, Town, or Location of Death Timonium If Under 1 Year If Under 24 Hrs.			4c. County of Dea Baltimor		ore		
	Director		217–48–47 Usual Residence of	'88	1 □ M 2 X F		8 Yrs.	Months				B. Date of B (Month, D ULY	ay, Year)	931 E		place (State or Foreign http) sburgh, PA.
7	ryland -f show ied at	ctor	10a. State W. Va. Maryland	10b. County	eley		City, Town or L			Hod	COCH	ille		-		10d. Inside City Limits 1 ☐ Yes 2 🔏 No
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3	ath wit ms 23 must	nuer	10306 Sun	ny Lake		cedent Ever in	110 112	Was Dass	odopt of U	21030	2/2000	. Voo or Na		Unite		
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UARY, Mar.	and 2 should be Health and Ment em 27 is markeu ther traumatic e		19a. Informant's Na Mr. Arthu			(son)				and Number o .ral Co				ty or Town, State, Zip Code) ater, MD. 21037		
FEBRUARY 11, Baltimore, Maryland	I T I		20a. Method of Disp 1 Burial 2 4 Donation	oosition Cremation 3 5 Other (Spe	Removal fro	m State	o. Place of Disp cemetery, cre Vans Fu	matory or mera	other place 1 Cha	pel F	eb. 2010	13,	Fc	Location - (prest	Hil	l.Marvland
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. Box 68760	death he atte ed for	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 9 ☐ Unknown	months? No	1 🔲 Liv	utcome of precede Birth 2 Feature Figure 1 Feature 1	etal death 3	Ectopic Other (s	pregnanc spec <i>ify)</i>	у				23d. Date Mont		ery Day Year
UISE Is, P.O	uires that t n signed b ıld be deta	ed by P	Part II. Other signifi	icant conditions	s contributing to	death but not	resulting in the	underlying	g cause giv	en in Part I.						he cause of death?
BLACKBURN, MARYLOUISE Division of Vital Records, P.O	the Hospital or Attending Physician: The law requires that the hin 24 hours after death. the Funeral Director: After this certificate has been signed by the rupleted filled in by the funeral director, page 2 should be detach	omplet									-	24a. Was auto perf	an opsy ormed? 2 2	pr	ior to co ath?	psy findings available impletion of cause of
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RN,	Physic this c	2	1 Yes 2 2 27. Manner of Death				ER/Outpatie			4 Nursir						/)
BLACKBURN	tending leath. tor: After the funer	Certificate:	1 A Natural 2 Accident 3 Suicide	5 Pending Investigat 6 Could no	ion	e of injury onth, Day, Year)		М			- 1	d. Describe	how inju	ry occurred		
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1	he Hosp in 24 hou he Funei ipleted fil	Medical	(Check 2 only one) 3	Certifying N ∴	miner: On the b	asis of examina	tion and/or inves	stigation, in	n my opinic	n, death occur	rred at the	e time date	and plac	e and due t	o the ca	use(s) and manner stated
5	To t To t		29b. Signature and	fulle of certifier	CRN)		29	R15	number 025	7		29d. D	Bd. Date signed (Month, Day, Year)		
	,		30. Name and addre				em 23a) (Type,					ית דותי	ONIL	IM MI	· · · ·	21093
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	Registra	ar	F	ED 7 9	W10 /	Variation of	A. A	mile	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 03563 Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month 10:00 A M Leonard Brooks, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1**√**M 2□F Months Days Hours Min. 036-14-9520 December 14,1922 New York 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Baltimore 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 8810 Walther Blvd., Unit 2127 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cowen Asset Elementary/Secondary (0-12) College (1-4or 5+) Portfolio Manager 12 5+ Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leanard Brooks, Sr. Irene Hicquins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd, Unit 2127, Baltimore, Maryland 21234 Katherine M. Brooks - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel & Cremation Services Belair 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/2010 Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkville 21. Signature of Funeral Service Licenses 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tracrania day disease or condition resulting in death) Due to (or as a consequence of): pertension year if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/ 1 Yes 2 No 25. Was case referred to medical

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

with

Baltimore, Maryland 21215-0036

Pages 1 and 2

Director

Funeral

Completed by

Be 2

Department of Health and Mental Hygiene. Important; if item 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Martical Examinations to any injury or other traumatic event, It. Martical Examinations and other traumatic event, It. Martical Examinations and other traumatic event, It. Martical Examinations are approximately and other traumatic event, It. Martical Examinations are approximately and other traumatics and other traumatics are also and other traumatics.

burial-tran and attending physician for use as the burial Physician/Medical is certificate has been signed by the director, page 2 should be detached ð Completed Certification: To in by the funeral

Hospital or Attending Physician. The law requires that the death certificate be executed

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After

after death.

24 hours a Funeral I filled

within 2 To the

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant

26. Place of Death (Check only one)

examiner? 1 Yes 2 □ No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier O.M. seller. B. trau

and manner stated.

29c. License number D36663 29d. Date signed (Month, Day, Year) 02/09/2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

in Square Dr. Balto, MD 21237

State Registrar

Medical

Fu Dir

		For State Registrar	Sta	ate of M	arylan		artmen rtificate			and M	ental Hy	giene, Reg. No.		03564
		1. Decedent's Name (First, Middle	e, Last)								2. Date of De	ath Day	Year	3. Time of Death
nysici: 'Medic		Patricia	K.	Booth							Februa		0, 2010	9:00 P ^M
xamin	er	4a. Facility Name (If not institution					4b. City,	Town, or	Location o	f Death		4c. (County of Deat	th
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to to	ìre	10e. Street and Number	J <u>7</u>				10f. Zip					10g. Citiz	en of What Co	ountry?
at pa	al	415 Russell Av	venue	#502			2	20877	7			Į	United	States
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mati	2	19a. Informant's Name/Relations				19b. Maili	na Address	(Street a					Town, State, 2	Zip Code)
rtrau		Henderson D. Bo		,			_					-		MD 20877
othe	-	20a. Method of Disposition	30 (11) 11	<u>ubbaria</u>	20b. P	lace of Disperentery, cre					ate		cation - City or	
- o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		al from State					1	, 2/1	6/2010	Mod	Ahino	Maryland
Imporant, I tem 21 is marked other trian inducat, or tems 238 or 26a-1 snow any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service			11.111									
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r use	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date										3d. Date of del		
should be detached for use as	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4	☐ Pregnant a ☐ Unknown			Other (sp.						Month	Day Year
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page	Completed										perfe	rmed? 2 1 No	death?	2 □No
ctor,	Be (25. Was case referred to medical examiner?							26. Plaçe	of Death	(Check only	one)		
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nera	ü	27. Man er of Death 1 V Natural 5 ☐ Pendin		a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe	how injury	occurred	
the fi	cati	2 Accident investig 3 Suicide 6 Could i	gation				М		/es 2 □ N ——	Vo				
n by	Certification:	4 Homicide determ		e. Place of Inj building, et	ury - At ho c. <i>(Sp</i> ec <i>if</i> y	me, farm, st /)	eet, factory,	office		2	28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,
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completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: (on the basis o	of examinat	wledge, dea tion and/or i	n occurred investigation,	at the tim in my op	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time	date and	and manner as place, and due	s stated. e to the cause(s)
mple	Med	29b. Signature and title of certifier		nd manner st	ated.		290	License	number			29d Date	signed (Monti	h Day Year)
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						refa.	4/1	20	7/4	7	• / / /	110"	VICE I	7 200
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVENUE (4. ROBERT BIRSCHBALL, WILL, CAITHERS BURG, NIN, 20877												
Sta	'o	31. Date filed (Month, Day, Year)	- 1,00	32. Registr			17	4 16	• '7(رمی	SUCK	100		/
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ EB CMenth PYARI BEGUM 2010 06:20AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Howard Ellicott City Health & Rehab 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F (Month, Day, You 26 Hours Year) 78 Director N/A India Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 🚈 No Catonsville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 21228 India 1206 North Rolling Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian .0. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: 3X Widowed 4 ☐ Divorced Asian Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Disabled Disabled na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Begum Mohammed Ibrahim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 North Rolling Road, Catonsville, Mohammed Aijaz-Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/12/10 Woodlawn, Md 4 Donation 5 Other (Specify) Signature of Funeral Service Liga Marchad for the owell to Thankson ram 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Pnysician/ CARDIO PULMONARY Medical resulting in death) Due to (or as a consequence of) Examiner ARTERY CORONARY DREVIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami HYPERTENSION To the Hospital or Attending Physician; The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical DISEASE RENAL STAGE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month 9 Unknown detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBROVASCULAR A-COIDENT 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' HTPOTHYROID After this certificate 1 ☐ Yes 2 ☐ No Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 ANo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1' Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Prijection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) PHYSICIAN 0062704 12,2010 FB

State Registrar

30 Name and address

No 31. Date filed (Month, Day, Year)

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ELLICHT GITY MD

21043

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Road

Ridge

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Bynum 9:40 PM Christine Feb 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🛭 F Months Days Min. 85 215-22-0880 01 Director 04 SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evaminar must be notified at appear. Once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X□Yes 2□No Director NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **4111** Rokeby Road 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Specify: Specify: Black g Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Assembly Worker General Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ben Wise Celest Windom ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Bynum-Terrell 5313 Windsor Mill Road, Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 2/20/10 Woodlawn, Md 21. Signaturi of Funeral Service Licens Marchand Address of Facility 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Approximate Interval Between Onset and Death Physician Congestive 12 das disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) by the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ailu 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No certificate 2/**X**/No ! □Yes 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day.

32. Registrar's Signature

		-	For State Registrar	State of	Marylan	-	artment of F		d Mental Hy	giene Reg. No 201	0 03567
	Physici	an	1. Decedent's Name (First, Midd						2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic	al	Susanne	Bash					Februar	7	
	Examin	er	4a. Facility Name (If not institution Solomon's Nurs	-			4b. City, Town, or	olomons		4c. County of D	lvert
7	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. i	last birthday)	If Under 1 Year	If Under 24 h	Hrs. 8. Date of Birt	h 9.	Birthplace (State or Foreign Country)
	Director		215-54-6433	1 □ M 2 X F	78	Yrs.	Months Days	Hours N	November	11, 1931 Ge	ermany
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Manyla -f sho	to		gomery		Bet	hesda				1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	: Country?
	th with	Funeral Director	5626 Bradley E	31vd.			2081	14		United St	tates
	tems	nue	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - A Black, W	American Indian, /hite, etc.
36	rs afte		1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	I If Ves Give	9		1 □Yes 2 XNo	Specify:		Specify:	White
9-0	2 hou latura ical E	ted	15. Deceder	nt's Education			dent's Usual Occup		warking	16b. Kind of Busine	ess/Industry
21215-0036	ithin 7 ne. nan "r	Completed by	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	DO NOT use retired Homemaker	f)	Working	Own Ho	mo
12	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ant, the Medical Examinat must be notified at	S	17. Father's Name (First, Middle,			1	Tomemaker	18. Mother's l	Name (First, Middle,		inc
Maryland	nd 2 should be filed within alth and Mental Hygiene. 27 is marked other than ir traumatic event, the Ma	To Be		1scheid				Eva		vailable)	
ary	should I and Men s marke	-	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number of	r Rural Route Numb	er, City or Town, Sta	te, Zip Code)
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan artiment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show ortant: If Item 27 is marked other than "natural"; or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at injury or other traumatic event, the Medical Examinar must be notified at §.		William C. Bas	hore, Jr./			<u>-</u>		Bethesda,	Maryland	
Baltimore,	permit. Pages 1 a Department of Her Important: If Item any injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 🗆 Removal from Si			sition (Name of matory or other place	:	bruary	20c. Location - City	
Ţ,	it. Pa rtmen rtant: njury		4 Donation 5 Other (S		EVE	_	Cemeter	1-2	, 2010	• •	Pennsylvania
Bal	permit. P Departm Importar any injur		21. Signature of Funeral Service	Edition See	M01	305 R6	bert A. Pun 57 Wisconsi	phrey Fu n Avenue	meral Home/ , Bethesda,	Bethesda-Che Maryland 20	
	Physician / Medical Examiner physician and physician and ithe priviler-transit	ical Examiner	23a. Part 1 Inter the disease, o short or heart failure. Lis Immedia. Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	or as a consequent as a conseq	vascuence of):	ular p	4ccia	lent		Approximate Interval Between Onset and Death
P.O. Box 687	the death certific by the attending p ached for use as i	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 □ Pregna 9 □ Unkno	rth 2 ☐ Feta ant at time of c wn	Ideath 3[leath 5[☐ Ectopic pregnanc ☐ Other (specify) _		23e Did t	23d. Date of Month	f delivery Day Year te to the cause of death?
ds,	signed of be det		Alzheimer	1s Den	mentio	a E	nd-5	tage	_ 1 _ 1		Probably 4 Unknown
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Be	: The law cate has l	E O								osy prior rmed2 deat 2 X No 1 🗆	
Vital	ician: The certificate rector, pag	Be C	25. Was case referred to medica	ıl				26. Place of	1 ☐ Yes Death (Check only o		163 2410
of V	Physic this ce al direc		examiner? 1 Yes 2 No		patient 2 🗆			4 Nursir		dence 6 Other	Specify)
	ding After fune	ü	27. Manner of D ath 1 Natural 5 □ Pendi	28a. Date o ng (Month igation	f Injury n, Day, Year)	28b. Time o Injury	Wor	yat° k? Yes 2 ∐ No	28d. Describe	how injury occurred	
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<i>~</i>	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification: To	(Check only 2 Medica	ng Physician: To the I	sis of examina						
5	thin 2 the lot	Med	29b. Signature and title of certific	and manne	e stated.	1	29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
	7 wit		1 Kong	1/1 (the	an Vi	2111	Don	5241	7/	Februar	u8. 2010
			30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type,	Print)	10	14	· JUNUI	b)
			Thomas Ann	ulis, M.D	2049	15 Gr	eat Mill	SKoa	d#203;L	exington	100/K, MD 20653
	Sta Registi		FEB 16 20	10 Lenn	gistrar's Stana	for			/	<u> </u>	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryla	•			/lental Hyg	giene				
		1 - State Registrar	Cer	tificate of D	eath	T	Reg. No.2	193568			
Physic		1. Decedent's Name (First, Middle, Last) Robin West	Bu	ırke		2. Date of Dea Month February		3. Time of Death 7:30 A. M			
Med Exam		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th			
2		11901 Rockinghorse Road		Rockvil			Montgom				
Funera Directo			. last birthday) 54 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day Nov 19	9. Bi (, Year) 1955 Mar	rthplace (State or Foreign ountry) y Land			
d t t	٦.	Usual Residence of Decedent 10a, State 10b, County 10c, C	City, Town or Loc	cation				10d. Inside City Limits			
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he Mis or 28; notii	ğ	Maryland Montgomery Ro-	CRVIIIC	10f. Zip Code		Т	10g. Citizen of What C	ountry?			
with t	Funeral Director	11901 Rockinghorse Road		20852			United Sta	ites			
leath items er mi	諨	11 Marital Status 12. Was Decedent Ever in U	J.S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spanic Origin?)	ecify Yes or No- Bican, etc.)	14. Race - Ame Black, Whit				
al", or	d by	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 💢 No			Specific	ite			
hours natur	Completed	15. Decedent's Education	16a. Decec	dent's Usual Occupa	ation	ing	16b. Kind of Business				
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y with ygien her ti	Be C	2	Loan	Processo			Mortgage				
e filec ntal H ed ot	일	17. Father's Name (First, Middle, Last)					Maiden Surname) ►				
Tyle		Paige Matthews West 19a. Informant's Name/Relationship (Type, Print)	10h Maili	na Addresa (Stroot a		Schmid	City or Town, State, Z	in Cadal			
NICA 2 Sho Iffh an 27 is 1 trau		Richard E. Burke/Husband	1					yland 20852			
T and t Hea		20a Method of Disposition 20b	Place of Disno	sition (Name of	1	Date uary	20c. Location - City o				
Page nent o int; If		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	irklawn Par	matory or other place Memorial k	17.	2010	Rockville,	Maryland			
partitione, inicity plants at 12.13-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	1000	21. Signature of Funeral Service Licensee	22	Name and Addres	s of Facility Rob	ert A.	Pumphrey Fu Montgomery N-2805	ineral Home Avenue			
		23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	ath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between			
Physician	/	Immediate Cause (Final disease or condition a Myocardi	al Infa	rction				Onset and Death One Hour			
Medica Examine	al	resulting in death) Due to (or as a conse	equence of):		Diagona			Ten Years			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Atherosclerotic Vascular Disease Due to for see a consequence of y									
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VILCII ysician: is certific director,	o Be	examiner? 1 \(\begin{align*} \text{Ts} \text{ Yes} & 2 \end{align*} \) No 1 \(\begin{align*} \text{Hospital:} \\ 1 \end{align*} \) Inpatient 2 \(\begin{align*} \text{Inpatient 2} \\ \end{align*} \)	☐ EB/Outpatie	Othe	er.		lence 6 🗆 Other (Spe	cifyl			
g Phy g Phy er this eral d	<u>ا</u>	27. Manner of Death 28a. Date of injury	28b. Time of		at		ow injury occurred	City)			
on on one of the control of the fun	licat	2 Accident Investigation	linjury	M 1 🗆	Yes 2 No						
DIVISION OF VITAL RECORDS, F.O. BOX OF The Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (S City or Tow	itreet and Number or Ri n, State)	ural Route Number,			
Hospit 4 hour Funera ted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examinat	tion and/or inves	stigation, in my opinio	n, death occurred a	it the time, date a	nd place, and due to the	cause(s) and manner stated.			
ithin 2	ž	only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier	my knowledge,	death occurred at the			e cause(s) and manner a 29d. Date signed (Mon				
F 3 F 0		> musy yours		D318:			February 1				
		30. Name and address of person who completed cause of death (Ite	em 23a) (Type, F								
		Christopher C. Dunford, M.D.,	, 615 W	. Montgom	ery Ave.	, Rockvi	11e, MD 20	850-3834			
St	tate trar	31. Date (iled Month, Day, Year) 32. Registrar's Sign	nature	1							

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 201 0 ar 5:30 PM S. Burn Florence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Annapolitan Assisted Living Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours Yrs. Pennsylvania January 19, 1924 Director 86 203-16-1042 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Eventing must be multiple another another must be multiple another. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 27 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g, Citizen of What Country? 21401 United States Funeral 84 North Old Mill Bottom Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. by Specify: 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Executive Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmy Weinseimer Walter Corwin Senger မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 South 1st. Street, Denton, Maryland 21629 Barbara B. Martin/Step - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 13, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy-Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En any certific Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 ☒ No Month Year Day 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, Completed by page 2 should be Failure to Thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an Vital 1 □ Yes 2 ▼ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{X}$ Other (Specify) Living 1 Tes 2 No Hospital: ot in by the funeral dir Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide lled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 9, 2010 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aditya Chopra, M.D. 600 Ridgely Avenue #231, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Server S. parks Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Keith Brown Donald February 20°I°b 8:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Olney Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Months Days Hours February 20, 1928 West Virginia 81 Director 233-38-6303 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 ី No Silver Spring Montgomery Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 3310 N. Leisure World Blvd., #403 20906 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. WWII ed other than "natural", event, the Medical Exa Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "ns any injury or other traumatic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Benjamin Brown Nona Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lynn Davis / Daughter 18609 Sunhaven Court, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State February Norbeck Memorial Park Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Strake Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Year LROTO Stenesu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (of as a consequence or, ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after No une vithin 24 hours after To the Funeral Dir the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 PRINCE 20832 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g900 2-16-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 8:12 am GOLDIE Cles 2010 BRILL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ba Himore SINAL HOUPITAL BALTIMORE OF N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Months Hours Min. 01/23/1921 Country) Director 253-14-5993 GA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 6503 PARK HEIGHTS AVENUE, #20 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, r than "natural", or ite the Medical Examiner Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 21215-0036 1 Yes 2 X No Specify. Specify: WHITE If Yes, Give 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) SALES RETAIL Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ BERMAN MOLLIE Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 REGINA JACOBS / DAUGHTER 9705 WINANDS ROAD, RANDALLSTOWN, MD 21133 Baltimore, but 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of M Femetopy, cometon an other place)
BETH ISRAEL 4 Donation 5 Other (Specify) 02/09/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility OL LEVINSON & BROS., INC. ROAD, PIKESVILLE, MD 21208 S₀L Le 8900 REISTERSTOWN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Frrysician/ SEPSIS disease or condition resulting in death) WEEK Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Chronic respiratory failure 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic 24b. Were autopsy findings available prior to completion of cause of carwire 24a. Was an autopsy death? After this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of centifier 29d, Date signed (Month, Day, Year) MBBS les-coo 06 2010 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Juis Royas-CALPERON SINAL MBBS MODITAL OF BALTIMORE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 03572 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ HOWARD 8: ZOPM BLUM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore Baltimore City N/A 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpiac Country) MD Months Hours Min 1/27/23/1941 Director 212-40-1330 68 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits be notified 1 X Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **Examiner must** 6320 GREENSPRING AVENUE 21209 items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ō 1 Never Married 2 X Married Black, White, etc. Completed by 1 ☐ Yes 2 X No Specify 3 🗌 Widowed 4 🗆 Divorced Specify: WHITE "natural", Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Health and Mental Hygiene. College (1-4 or 5+) Page 1 and 2 should be filed within SALESMAN LIOUOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BLUM Department of Health and Men Important: If item 27 is marke any injury or other traumatic **FLORA** COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN BLUM / WIFE 6320 GREENSPRING AVENUE, #407, BALTIMORE. MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LUBAWITZ NUSACH ARI 2/15/2010 ROSEDALE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Acute Respiratory Distress Syndrome
Due to (or as a consequence of): 10days Medical Examiner <u>Pneu monia</u> Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Sepsis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a Was an After this certificate has performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 은 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

31. Date filed (N

Howard

Singi Hospital of Baltimore

releted cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FBRUARY 9:057 M BENJAMIN 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SANCTUARY AT HOLY CROSS MONTGOMERY BURTONSVILLE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiece Country) **Funeral** 1 - M 2 X F Min. 0471671919 326-16-2585 **Director** 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho: 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No MD MONTGOMERY BURTONSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3415 GREENCASTLE ROAD 20866 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. Completed 3 X Widowed 4 Divorced Year or Dates WHITE other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) DEVELOPMENT DIRECTOR HEBREW UNION COLLEGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WILLIAM EICHENBAUM HELEN WEISCZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau ROBERT BENJAMIN / SON 10109 CARILLON COURT, ELLICOTT CITY, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 02/09/2010 CINCINNATI, OH 4 ☐ Donation 5 ☐ Other (Specify) UNITED JEWISH CEM. 21. Signatur of uneral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Ph sician/ ONGISSTUE disease or condition resulting in death) Medical Examiner 755032 if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗆 No I 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: <u>-</u> 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, dea ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2835

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMITH AVENUE, BALTILIORE, HAMP

088852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) Rea. No. Physician /Medical 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. Date of Birth Month Day, **Funeral** Months Days Hours Min. Director or items 23a or 28a-f show 10d. Inside Oity Limits traumatic event, the Medical Examinant nust be notified at Director 1 ☐ Yes 2 ☐ No Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify: 3 Widowed 4 Divorced natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done diffing most of working I Hygiene. Elementa Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if item 27 is marked other the one blury or other traumatic event, it alone. Be Place of Disposition (Name of cemetery, organizatory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) the detached 9 Unknown funeral director, page 2 should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 \sum Nursing Home 2No 1 ☐ Yes Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 5 ☐ Residence 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural Accident 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide The physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

31. Date filed (Month, Day,

10-01092 Floyd Baker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Floyd Baker	1- For State Registrar		r Maryland / L	Department o Certificate o		d Mental I		eg. No. 201	0 0357
Physician Medical Examine		e (First, Middle,Last) Baker					2. Date of Dea Month February	Day Year	3. Time of Death 1925 hrs
	4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Dea		4c. County of De	eath
Funeral	Johns Hopk 5. Social Security N	kins Hosiptal	7 Age (II	n yrs. last birthday)	Baltimore	r If Under 24H	re 8 Date of Bir	N/A	Righnian (State or
Director	213-84-4	1252 1□M	2 X F	47 Yrs	Months Day			Foi	reign Country) Md
any	Usual Residence o 10a. State	f Decedent 10b. County	100	c. City, Town or Local	ion				10d. Inside City Limits
	Md.	N/A		Balti	more				1 X Yes 2 No
the Maryland as or 28a-f show officed at once.	10e. Street and Nu				10f. Zip Code		1	0g. Citizen of What C	ountry?
ith the notified in I Die	4905 Cc	ordelia A			212			USA	
death with	11. Marital Status 1 Never Marrie		2. Was Decedent Eve Armed Forces?	If Y	s Decedent of His es, specify Cubar			- 14. Race - Ал White, etc	nerican Indian, Black, :
after dall, or iner m	2 NASidoward	4 Divorced If	Yes 2 X Yes, Give Year Dates:		Yes 2XX No	specify:		Specify:	Black
5-0036 ed within 72 hours afthe description of the result of the matural. Commission of the matural of the Medical Examine of the medic	15. Decedent's Ed	ducation (Specify only	nighest grade comple College (1-4 or 5+)		nt's Usual Occupations of working life			16b. Kind of Busines	ss/Industry
336 thin 72 ne. than edical	12	oridary (0-12)	College (1-4 of 5+)	Truc	k Drive	ar.		Private	
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica		(First, Middle, Last)		1140			ne (First, Middle, I	Maiden Surname)	
lD 21215-00; should be filed with and Mental Hygiene 7 is marked other th natic event, the Mes		Floyd B		19h Mailin	Address (Street	Shirle	y Hill	nber, City or Town, Sta	ata Za Oada)
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. Ten 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at once. To Be Commisted by Ermoral Director		Coleman	, ,	1				e, Md. 21	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", or itens 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Firnaral Director	20a. Method of Disp		Removal from State	20b. Place of Dispos crematory or ot	ition (Name of cer	metery,	Date	20c. Location - City	or Town, State
Limo Page ment o	4 Donation 5	Other Specify:		Mt.Zion	Church	Cem 2/	17/10	Pasadena	a,Md.
Ball permit Depart Impor	21 Signature of Fu	neral Service Licens	1.0	Ës	lame and Address Tep Bro	thers	Funeral	l Service	e,PA
Physician	23a Part I Enter th	e disease, or complica y one cause on each	tions that caused the	death. Do not enter the	ne mode of dying,	such as cardiac	e, Bal or respiratory arre	timore, Mo	Approximate Interval
Examiner	Immediate Cause (I	Final disease a. Ná	rcotic in		1				Between Onset and Death
	or condition resulting	, but	to (or as a conseque	ence of):					
	Sequentially list con if any, leading to im cause. Enter Unde	mediate Due	to (or as a conseque	ence of);					
red Insit	(Disease or injury a events resulting in a	nat initilated =	to (or as a conseque	ence of):					
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit no. To Be Completed by Physician/Medical Ex.	X UNPENDED	d	MENDED						_
60, ate be execut hysician and e burial - tra	IF FEMALE:		MENDED 23a, 2		ermE, g90	00 2/24/	10 TT	23d. Date of delive	erv
Ox 6876 eath certificate attending phy for use as the I	23b. Was decedent past 12 months	pregnant in the	Live birth Pregnant at time	2 Fe	tal death 3 [Ectopic pregr	ancy	Month	Day Year
). Box 68760, the death certificate be by the attending physic ched for use as the bur Physician/Mec	1 Yes 2 N	lo 9 Unknown	Unknown	5 Ott	ner (Specify)				
P.O. ss that the gned by the detache		icant conditions con	ntributing to death but	t not resulting in the u	nderlying cause g	iven in Part I.		bacco use contribute	
ds, Fraguires 1							1 Yes		obably 4 Unknown autopsy findings available
of Vital Records, Is Physician: The law requires ther this certificate has been signeral director, page 2 should be 1: To Be Completed					_		autops perfor	sy prior to med? death?	completion of cause of
tal Rection: The certificate ector, page					26.Place	of Death (Check	1 Yes 2	2 No 1 🗸	Yes 2 No
Vital hysician this certi	1 🗸 Yes 2	Z NO		2 ER/Outpatient		Other Nursi	ng Home 5 1	Residence 6 Oth	ner
C = - 0	27. Manner of Death 1 Natural	5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Ir		y at Work? es 2 No	28d. Describe h	ow injury occurred	
Division rs after death. at Director: A led in by the fu	2 Accident 3 Suicide	Investigation 6 Could not be	Fd 2/6/10 28e. Place of Injury	Fd 6:30	t, factory, office b	uilding, etc.	28f. Location (S	treet and Number or F	Rural Route Number, City
Spiral or Attending spiral or Attending nours after death. Increal Director: Affilled in by the fun	3 Suicide 4 Homicide	determined	(Specify) Joh	ns Hopkins	Hospita	11	or Town, St Baltimor	ate) Wolfe St	treet
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificati	29a Cermer	Certifying Physician: Medical Examiner: On	the basis of examinat						
A S T S S O	29b. Signature and t		manner stated		29c. License		_	29d. Date signed (M	fonth, Day, Year)
	Theodo	W. L	TATR.	u. D.	O.C.N	ı.e. OCM		February 8, 201	10
		ss of person who com King, Jr., MD.	Assistant Medic	,	111 Penn Str	eet. Baltimor	e. MD 21201	- 17 11	
State			32. Registrar's Si		<i>a</i>		_,		
Registra	1 1.10	10 4010	is some for	· ACPARAGE	ř.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lemuel Blake Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Raltimore Union Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 3, 1953 **Funeral** 9. Birthplace (State or Foreign Months Days Min. Country) Maryland 1 **X**M 2 □ F Hours Director 212-58-1252 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 H Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 U.S.A. 4134 Norfolk Avenue 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc ò 1 Never Married 2 XMarried 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 XNo Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Gang Leader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sarah Blake Lemuel Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4134 Norfolk Avenue Baltimore, Maryland 21216 Alicia Blake Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 02/04/10 Lansdowne, Maryland 4 Donation 5 Other (Specify) Mt. Zion Cemetery Simplare of Fineral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P 300 Eutaw Place Baltimore, Md 21 Part 1. Enter the disease, or complications that caused hock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 181 Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. as the burial-transi neumonis rate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy prior to completion of cause of death?

1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 은 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Tyes Accident 2 🗌 No Investigation **Director:** 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, 24 hours Medical 1 Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

WNION MEMORIAL HOSPIT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:05 PM 2010 February Kevin T. Brushe 03 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner St. Agnes HOSA) Itimare If Under 1 Year | If Under 24 Hrs. Hours | Min. 8. Date of Birth (Month, Day, Year) 11/15/1952 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ★M 2 ☐ F 58 218-60-2566 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Item Modical Event or other traumatic event, Item Modical Event or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 No **Funeral Director** MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 Taylor Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 <u>Service Manager</u> Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary O'Donnell Raymond E. Brushe ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1220 Taylor Avenue, Halethorpe, Maryland 21227 Jeanne C. Brushe (Spouse) Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. rignature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of) Embolic Strokes Examiner tiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner The law requires that the death certificate be executed ordiany opa thi burial-tra Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Alcaholism Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ☐ Probably 4 ☐ Unknown 2 No certificate has been ppac 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 □ Yes 2 No Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA this Medical Certification: To o 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident or Attending Division 5 Pending investigation 1 ☐ Yes 2 🗆 No after death Director; filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 03 re and address of person who completed cause of death (Item 23a) (Type, Print) Avenue 900 Caton 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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			For State Registrar		State of M	laryland		artmen <i>tificat</i>				ental Hy	giene Reg. No.	2010	03	578
-	Physici	an	1. Decedent's Name			1						2. Date of De Month	Day	Year		of Death
	/Medic		Mary 4a. Facility Name (If	Dee not institution, giv	Cunning re street and number			4b. City,	Town, or	Location	of Death	Februa	1:3	0 P M		
	LXaiiii	ici		Silver		-				er Sp				Montgo		
di a.	Funeral Director		5. Social Security N 497-01-	-3508	Gex 1 □ M 2 1 F	ge (In yrs. Ia 92	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Da June 10	av. Year)	9. Bir C L7 Ter	thplace (State ountry) nessee	or Foreign
	ow at		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo			·					10d. Inside	City Limits
	e Mary ta-f sh tified a	ctor	MD	Montgo	mery			Si	1ver	Spr	ing				1ХХҮ∈	es 2∏No
1	th with the	al Director	10e. Street and Nur 2700 Ba	nber arker St.				10f. Zip	Code 209	910			_	en of What C ed Sta	-	
980	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1		12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No		Was Dece f Yes, spe 1 □ Yes		ispanic Ori in, Mexical Specify:		cify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify:		
Maryland 21215-0036	vithin 72 ho ane. Ithan "natui ie Medical	Completed	(Spec	15. Decedent's E ify only highest gra ndary (0-12)	ducation ade completed) College (1-4or 4	5+)		lent's Usu kind of wo DO NOT u Nurse	rk done d se retired	ation during mos l)	st of workir	ng		d of Business spital	/Industry	
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ylan	Menta Menta arked aric ev	To B	Joe	Milt		illips	5			J	osie	E	Elizab	eth	Lind	sey
, Mar	and 2 sho salth and 1.27 is ma er trauma		19a. Informant's Na	me/Relationship (inningham			1					i Route Numb Lver Sp			Zip Code) 20910	
Baltimore,	Pages 1 anent of He ment of He mt: If item my or oth				Removal from Stat	e	ace of Dispo emetery, cren 1e Gro			1		/2010		ation - City o		
Balt	permit. Departr Imports any Inji		21. Signature of Fu	neral Service Lice	risee W	10038.	2 Re	Name ar eeds 02 We	d Addres Chap st C	el Mo hurch	ortua n St.	ry , Lexi:	ngton	, TN	38351	
4	Physician /Medical Examiner		shock, or heal Immediate Cause (disease or condition resulting in death)	rt failure. List only Final n	· ·	ed the death line. umonia s a consequ	. Do not ent								Approxim Interval B Onset an	etween
	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause Disease or that initiated events resulting in death) L	nditions, immediate rlying and injury asst	C	s a consequ s a consequ										
P.O. Box 68	ictan: The law fequires that the death certificate certificate has been signed by the attending phrector, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 № 9 ☐ Unknown	months?	1 ☐ Live birth	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							23d. Date of delivery Month Day			Year
rds, P	quires that n signed t uld be deta	þ	_		contributing to death			, ,	ause give	en in Part i	l.				o the cause o Probably 4⅓	
Division or Vital Records,	The law re- ate has bee bage 2 shor	Completed										24a. Was auto perf 1 Yes		prior to death?	utopsy finding completion of	s available cause of
/ita	rhysician: rthis certifica ral director, p	Be	25. Was case reference examiner?		Hospital:				Loui		e of Death	(Check only				
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ion	Attending It death. ector: After by the fune	ation	1 X Natural 2 ☐ Accident	5 ☐ Pending investigatio	(Month, E	lay Year)	Injury	M	Work	k? Yes 2 □			,,			
Divis	lo the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	Zee. Place of I	njury - At hor etc. (Specify	me, farm, str	eet, factor	, office		2	28f. Location City or To	(Street and wn, State)	Number or F	lural Route No	umber,
1	le Hospit 124 hours le Funera pletely fille	Medical (29a. Certifier (Check only one)		hysician: To the bes miner: On the basis and manner:	of examinat										⇒(s)
\	within To the	Me	29b. Signature and	title of certifier				29	. License	e number			29d. Date	signed (Mor	th, Day, Year,)
			30. Name and addr	ess of person who	completed cause of	death (Item	23a) (Type,	Print)	D098	334			Fe	bruary	7 11, 2	010
	Sta		BARRY 31. Date filed (Mont	N KOSE th, Day, Year)	completed cause of MBAUM 32. Regis	MD trar's Signat	3729 ure	O FA	RRA	76.11	TH	IE, Ki	ENSI	NGTO	NIGO	24015
DHM	Registi IH 17 Rev 1/2			FEB 16	2010 2	de la	A. 18	park		-						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Bradford Coolidge 6:30 AM M February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5423 Mohican Rd. Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Jan. 20, 1916 Massachusetts 1**XX**M 2 □ F Months Days Min. Hours 94 Director Yrs 012-18-4308 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location the Maryland must be notified at 10d. Inside City Limits Directo MD Montgomery 28a-f Bethesda 1 X Yes 2 No b 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 5423 Mohican Rd. 20816 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. þ 1 XYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" 3XXWidowed 4 □ Divorced Specify: White Completed Year or Dates. 1941-45 event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than U.S. State Department Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Foreign Service Officer it. Page 1 and 2 should be filed w rtment of Health and Mental Hygi rtant: If item 27 is marked other njury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Bradford Coolidge Burleigh Ruth Dame 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth J. Coolidge / Daughter 21 Outlook Dr., Lexington, MA 02421 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 2/12/2010 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services M00382 Gist Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition Alzheimer's Disease year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence on Exami executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u. in the past 12 months? Pregnant at time of death Month Day Year 2 No Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performe death? 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a d title of certi 29c. License number 29d. Date signed (Month, Day, Year) D23556 February 12,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave. #1400, Chevy Chase, MD Robert H. Blee M.D. 31. Date filed (Month, Day, Year) 32. Reginature State 1. park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene 03580 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MARIE CRAMER FEBRUARY 8,2010 10:25PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SOUARE HOSPITAL ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 😿 F 86 Yrs 054-18-0392 Director 4-30-1923 NEW YORK Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD BALTIMORE PERRY HALL 1 ☐ Yes 2 TXNo Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 18 E. BROOKFARM COURT 21128 U.S.A. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ORLANDO GONDOLFO TILLIE (DiMARTINO) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar KENNETH CRAMER/HUSBAND 18 E. BROOKFARM CT PERRY HALL, MD permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-16-2010 GARDENS OF FAITH BALTIMORE, MD 21. Signature of Fundamental Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RAMME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation Ebructy 8, 2cto 0100 A M 10 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 □ Yes 2 ANo tal 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) / 8 E. BYRON FORM TO filled in by 4 Homicide Home Perry Hall 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

29b. Signature and tyle of certifier

Year)

S

KKW

P

ompleted cause of death (Item 23a) (Type, Print) MITI

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#22perFH, G900, 2/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene 03581 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 3. Time of Death Physician/ Month Year STEPHANIE ANNET CROWDER JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 - M 2 XF Days Hours Min. Months 577-90-9330 50 Yrs Director 28 1960 NORTH CAROLINA IAN Usual Residence of Decedent 10b. County items 23a or 28a-f sho ner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S CAPITOL HEIGHTS MD 1 🕅 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4616 HEATH STREET 20743 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No er than "natural", or iter the Medical Examiner Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. BLACK 3 XWidowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CUSTOMER SERVICE PRIVATE permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GOLDIE JONES ARLESTER WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4616 HEATH STREET CAPITOL HEIGHTS, MARTLAND 20743 RAISHAWN JONES/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State HERITAGE MEMO CEM: 02-12-10 WALDORF MD 4 Donation 5 Other (Specify) Murgay Fuberal Hom Signature of Funeral Service Licensee 22. Name and Address of Facility Washington D.C. 4804 Georgia Averant Kerner & wellens mo1182 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of burial-transi Cause (Disease or iinjury that initiated events NONISCHEMIC CARDIOMYOPATHY attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 💢 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed OBSTRUCTIVE SLEEP APNEA page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X** No Certificate: To 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA After this funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier

Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral D

> State Registrar

only one

29b. Signature and little of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA D. GREEN M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D21428

29d. Date signed (Month, Day, Year)

JANUARY 28, 2010

Kenneth Clinton	Please Type or Print in Black Indelible Ink. Ensure All Co State of Maryland / Department of Health and Menta 1- For State Certificate of Death		03582							
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death Month Day Year February 10, 2010	3. Time of Death 1325 hrs							
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of E 15 Charles Plaza Apt. 2904 Baltimore		ath							
Funeral Director	5. Social Security Number 002-58-8731 6. Sex 1 Months Days Hours 7. Age (In yrs. last birthday) 1 Months Days Hours	Min For	Birthplace (State or eign Country) MA							
Aaryland Aaryland Latonce ector	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 X Yes 2 No							
or the Maryland 3a or 28a-f sho officed at once.	10e. Street and Number 15 Charles Plaza, Apt# 2904 110f. Zip Code 21201	10g. Citizen of What C	ountry? SA							
21215-0036 Muld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Put No 1 Yes, Specify: No specify	uerto Rican, etc.) White, etc. Specify:	white							
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natur or other traumatic event, the Medical Exam To Be Completed It	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 Hair Stylist	e retired)	air							
21215-C uld be filed v Mental Hygi marked oth c event, the I	Kenneth L. Clinton	Name (First, Middle, Maiden Surname) Marlene Murphy								
MD and 2 sho salth and 2 sho sm 27 is raumati	19a. Informant's Name/Relationship (Type, Print) Marlene Cuthbertson / Mother 19b. Mailing Address (Street and Number 62 Hermit Lake Road 20a. Method of Disposition) 20b. Place of Disposition (Name of cemetery,		3269							
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	1 Burial 2 Cremation 3 X Removal from State Southern NH Crematory	2/18/10 Derry	, NH							
Physician	21. Signature of Funeral Service License Victor P. Doda, Jr Charles L. Steve 1501 East Fort 7 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	ens Funeral Home, Ir Avenue, Baltimore M jac or respiratory arrest, shock, or heart	Approximate interval							
Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrthythmia associated without the condition resulting in death) Due to (or as a consequence of):	h Cardiomegaly	Between Onset and Death							
red nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
executed an and al - transit	events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED AMENDED 23a,27 per me g901 3-25-10 v	rt								
ox 68760, ath certificate be arrending physici or use as the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1									
, P.O. Bo res that the de signed by the be detached f d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 Pr								
Records, The law requires ficate has been sig		autopsy prior to death? 1 ✓ Yes 2 No 1 ✓								
of Vital Recing Physician: The lands there is director, page funeral director, page on: To Be Com	- 102,	ursing Home 5 Residence 6 🗸 Oth	er: Scene							
Division or ital or Attending its or Attending its after death. The and Director: After its or the function by the function: ertification:	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No									
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place.	28f, Location (Street and Number or F or Town, State)								
To the Hos within 24 h To the Four completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time, date and place, and due to	the cause(s)							
	29b. Signature and title of certifier O.C.M.E.	29d. Date signed (N								
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01 30ay 20[°]10 Claiborne 5:45 a^M Bettie Gunby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Charles Village Baltimore N/A 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Min. Hours 02/24/1914 Maryland Director 02-24-1914 95 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 U.S.A. 422 Watty Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Personal Care Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Elton Wise Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Heloris B. Gunby (Daughter) 2217 Druid Hill Ave.1stFloor, Balto., MD21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Cemetery 02/15/10 Baltimore, MD 21. Signature of Funeral Service Licenses 2305ephdr H. Funeral Home elliano 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 10 ronaly Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 5 Month Year Pregnant at time of death Day signed by the at d be detached for Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗷 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier PHYSICIAN 9-1-2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE . SANDHU BALTIMURE 1940 W. MO 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 7/2009

68760

Box

P.O.

Division of Vital Records,

	Tor State of Maryland / Department of Health a Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Death 3. Time of Dea								
Physician/ Medical Examiner	Marjorie Coffy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	Festing Day 7, 20 7 9-30 4								
<i>)</i>	Baltimore Washington Medical Center Glen Kur	mit Anne Arund-								
Funeral Director	5. Social Security Number 6. Sex 1 Months 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Months Days Hours 1 Usual Residence of Decedent	24 Hrs. 8. Date of Birth 9. Birthplace (State or For Min. 10 20 21 936								
or 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Glen Burnie	10d. Inside City Lin 1 ☐ Yes 2X								
tems 23a or ser must be no Funeral Di	10e. Street and Number 10f. Zip Code 7832 Park West Drive Apt. 1 21061	10g. Citizen of What Country? USA								
fter of it or i	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1 □ Yes, specify Cuban, Mexican, 1 □ Yes, Give Year or Dates.	in? (Specify Yes or No- 14 Race - American Indian								
within 72 hours at giene. great than "natural" the Medical Exa. the Medical Exa.	15. Decedent's Education (Specify only highest grade completed) Elementary (Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) Business Owner	of working Record Store								
Id be filed v Mental Hyg arked othe atic event,	17. Father's Name (First, Middle, Last) John McConnell 18. Mother	r's Name (First, Middle, Maiden Surname) Marion (unkn)								
permit. Page 1 and 2 shou Department of Health and mportant: If item 27 is m any injury or other traum once.	Jennifer R. Batch/granddaughter 707 Summer Ridge Ct	or Rural Route Number, City or Town, State, Zip Code)								
t. Page 1 s tment of h tant: If ite ijury or ot	· El Senation o El enter (epoeny)	Date 20c. Location - City or Town, State Catonsville, MD								
permi Depar Impor any in	21. Signature of European Coordinate Licensess M01364 421 Crain Hwy SE	Kirkley-Ruddick Funeral Home P E Glen Burnie MD 21061								
Physician Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury) Cause (Disease or injury)									
ficate be executed g physician and as the burial-transit	that initiated events resulting in death) Last Due to (or as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year								
en signed bould be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
The law require cate has been signated and page 2 should the Completed		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 2 Yes								
hysician: nis certifi I director	25. Was case referred to medical examiner? 1	n (Check only one) / sing Home 5 ☐ Residence 6 ☐ Other (Specify)								
ding Ph h. After th funeral sate; 7	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work?	28d. Describe how injury occurred								
tal or Attending P rs after death. al Director: After t led in by the funers al Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital within 24 hours to the Funeral I completed filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place only one) 29b. Signature and the of certifier 29c. License number	curred at the time, date and place, and due to the cause(s) and manner s								
->-0	100 D4800	06 02/12/2010								
	30. Name and address of person who completed clause of death (Item 23a) (Type Print)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year HWA CHUNG 1524 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARCI LOWARD COUNTY GENERAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1**X** M 2□ F Months Days Hours Min 68 Director 04/04/1941 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BA/FIMON/-10e. Street and Number 10g, Citizen of What Country? ö 11 W 20th 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married ò 1 □Yes 2 No Specify: Specify: AS/AN þ 3 Widowed 4 Divorced Department of Health and Abhous Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", any injury or other traumatic event Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLOTHIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KWON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARK-SON-IN-LAW DEER LAKE St. CENTREVILLE VIA SUNGHOON 20b. Place of Disposition (Name of cemetery, prematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 2-15-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part T. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PIERO SCEROTIC CAR DIO MAS CULA E squestitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physlcian: The law requires that the death certificate be executed RENALF physician and the burial-trans CHRONIC Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ➡No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate | 1 ☐ Yes 2 ☐ No 1 ☐Yes After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1@ Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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HOWARD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3altimore, Maryland 21215-0036

P.O.

Records,

Vital

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 03586 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:45 2010 Robert E. Callahan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner osedale Baltimere Franklin Square If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/14/1920 Birthplace (State or Foreign Country) 6. Sex Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Pennsylvania Director 89 220-09-6855 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Montal Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Expraises must be rediffed at 1 □ Yes 2√2 No Director Baltimore Kingsville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21087 Completed by Funeral 7602 Chapman Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No if Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Esskay Meat Packing Mechanical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna B. Steinmetz Thomas D. Callahan, Sr. ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 7602 Chapman Road - Kingsville, Maryland 21087 <u>Patrick J. Callahan</u> (son) per nit. Pages 1 a
De artment of He
important: if item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/20/2010 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 11750 Belair Road - Kingsville, Maryland 21087 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** UNG emoyem disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, → attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe certificate 1 ☐ Yes 2 🖾 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this
filled in by the funeral di After this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

DHMH 17 Rev 1/2001

State Registrar

within 2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Lee 1

29c. License number

RESOCOO

Baltimore MD 21237

29d. Date signed (Month, Day, Year)

2010

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 franklin Square

bu Lin, NO

32. Registrar's Signature

Physician /Medical Examiner The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, as the l

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

is marked of 1 and 2 should be

> for use detached signed t page 2 should funeral director. this After after death Director: filled in by

or Attending

within 24 hours a To the Funeral I To the Hospital

28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Bellona Lome #216, Towsen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03588 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** : 538 M 91185 (00 P 2010 /Medical Februsy 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 388 Riverside Drive Pasadena Anne Arundel 6. Sex 1 M 2 □ F Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/30/1943 Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 215-40-6440 **Director** 66 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f shou ury or other traumatic event, the Medical Examinar mast be inclined at 1 ☐Yes 2 No Funeral Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 388 Riverside Drive 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Business Owner Heating & Air 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Floyd E. Cooper, Sr Edna May Horton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Jean Cooper/Wife <u>388 Riverside Drive, Pasadena, MD 21122</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02/09/10 | Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee Riviera Drive, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause in the distribution of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ZNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 13 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and litle of certifier 29c. License number 30. Natural address of person who completed cause of death (Item 23a) (Type, Print)

) V

State Registrar 31. Date filed

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32. Registrar's Signatur

(Month, Day, Year) **B** 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Maurice Charles Cusick 2010 7:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 428 3rd Avenue S.W. Glen Burnie Anne Arundel 5. Social Security Number 7. Age (Irr vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Feb. 27, 1920 215-16-3392 89 Director MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 428 3rd Avenue S.W. 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married þ 1 ☐ Yes 2 No Specify Specify: White item 27 is marked other than "natural", other traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 Supervisor Koppers Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar C. Cusick Grace Gootee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health Harriet Drive Glen Burnie, MD 21060 Mrs Anne McFarlan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park! 12, 2010 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Crmeation attletor Services PA 1 2nd Ave. SW GLen Burnie, MD 21061 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) UPGI Medical Due to (or as a consequence of) Examiner par Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ 1 Yes 2 1 4 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed this certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🗆 🛚 in 24 hours after very the Funeral Director. After this cannot filled in by the funeral director and the funeral director. မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred al or Attending F s after death. Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ A... ☐ Suicide ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 00 who completed cause of death (Item 23a) (Type, Print Jrbary (01 MM) 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

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Box

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Records,

of Vital

Division

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			1- For Amend Item 23 State of Maryland / Department of Health and M Registrar Certificate of Death	lental Hyg R	iene _{eg. No.} 2010	03590
	Physici	an	1. Decedent's Name (First, Middle, Last) Betty L. Cole	2. Date of Deat Month	Day Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	January	4c. County of Dea	03:25 a ^M
	Examir Funeral Director	ier	Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 217-26-5549 79 Yrs.	8. Date of Birth (Month, Day, Sept. 25	Anne An	tundel Co. thplace (State or Foreign ountry) Savage, MD
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	•		10d. Inside City Limits
	e Mary a-fsh	ctor	MD Anne Arundel Co Curtis Bay			1 ☐ Yes 2 🔀 No
	/ith the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
	eath v	Funeral	922 Lauren Way 21226 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	oifu Voc or No	United S	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventhan must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Rican, etc.)	Black, White	
2-0	72 hou	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	na	16b. Kind of Business	/Industry
121	within sene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	ly	Vestor	
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/lan	should be fand Mental s marked or umatic eve	To B	Howard Lowery Mary	Grady		
/Jan	es 1 and 2 should b of Health and Ment f item 27 is markec r other traumatic e	·	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural)	l Route Number	City or Town, State, 2	Zip Code)
	t and 2 Health em 27 I				ryland 211	
Baltimore,	Pages nent of int: If its iry or o		12 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Cemetery, crematory or other place) Glen Haven Mem. Park 2/4/20		Glen Burni	·
alti	permit. Page Department of Important: If any Injury of once.				Funeral &	
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and.	Physician /Medical	15	23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of):	r respiratory arro	est,	Approximate Interval Between Onset and Death
	Examiner					
	p #s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
_	ificate be executed g physician and ts the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
68760	e be e	calE	d			
_	rtificat ng phy as the	Medical				
P.O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of del Month	livery Day Year
	w requires that the description is been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to s 2 ☑ No 3 ☐ Pi	o the cause of death?
Vital Records,	ilcian: The law re certificate has be rector, page 2 sho	Completed		24a. Was ar autops perform 1 □ Yes 2	y prior to death?	utopsy findings available completion of cause of 2 □ No
<u> </u>	slcian certif irector	Be	25. Was case referred to medical examiner? 1 Yes 2 Mo Hospital: 1 Impatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home	· · · · · · · · · · · · · · · · · · ·		
Ö	g Phy er this eral d	n: 70	27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c.		nce 6 ☐ Other (Spe w injury occurred	cify)
Sior	endin sath. or: Aft he fun	atio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
DIVISION OF	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification:	4 Homicide building, etc. (Specify)	City or Town	,	
	the Hosp in 24 hou the Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To T Con	2	29b. Signature and fittle of certifier DOC 38445	21	9d. Date signed (Mont	h, Day, Year) 2-01 ()
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Anr	apulis, n	10
	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 6 2010 Street S. Jack			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 8:33A 1011 ICILIE 2010 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) Days Hours Min 1 M 2 X F Yrs 106-28-6037 73 June 27,1936 New York Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕱 No Maryland Howard Columbia 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7441 Swan Point Wav 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify Specify: **XX**Widowed 4 □ Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Poet Literary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Sayles Thelma Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexia Clifton (Daughter) 7441 Swan Point Way Columbia, Maryland 21045 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2x Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2-15-2010 Glen Burnie, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License 5555 Twin Knolls Road Columbia, Maryland 21045 ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Fart 1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Year Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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Examiner

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physician and as the burial-tran Physician/Medical signed by the at by Completed Be မ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed

has

filled in by the funeral

completely To the I

Medical

after death.

e Funeral I

Division of Vital Records, P.O. Box 68760.

				1 ☐ Yes 2	✓No 3 🗍 Probably 4 🗌 Unknow				
				24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
25. Was case referred to medical			26. Place of De	ath (Check only one)					
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Solution State of Injury (Month, Day Year) 28c. Injury at Work? M 1 □ Yes 2 □ No								
3 Suicide 6 Could not be determined	e 28e. Place of injury - At ho building, etc. (Specify		28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, death occurre	d at the time, date and place	e, and due to the cause(s)	and manner as stated				

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Res-000 and address of person who se of death (Item 23a) (Type, Print)

29d. Date signed (Monthy Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 03592 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Michael S. Cochran BI /Medical Town, pr Location of Death Facility Name (If not institution, give street and number, 4c. County of Death Examiner N/A 8. Date of Birth 10/21/1957 Social Security Number 9. Birthplace (State or Foreign . Age **Funeral** Hours Months Days 1 ₩ M 2 □ F Indiana 307-66-2101 52 Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ire Madical Examinas must be nother to one or other traumatic event, Ire Madical Examinas must be nother than Director 1 ∐ Yes 2 🕅 🗖 0 Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 1207 Circle Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Xes, Give Ye ar or Dates: 11. Marital Status Race - American Indian. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 □Yes 2 ∏ No Specify ģ Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custom Cue Maker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Cochran Mary Lou Cook ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Circle Drive, Arbutus, Maryland, 21227 Connie Cochran/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 2/14/2010 Glen Burnie, Maryland 15 □Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington BLvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myo cardial unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: detached for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No 1 ☐ Yes 2 1 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident after death filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Baltimore, Maryland 21215-0036

Registrar

29b. Signature and title of certif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Day, Year)

Baba Camara 10-00907

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

JNK UNK		Sta I- For State Registrar	ite of Maryland		rtificate of		and Me	ental H		Reg. No.	201	0 03593	
Physician Vledical Examine	-	Decedent's Name (First, Middle Baba Camara	,Last)			-			2. Date of De Month February	Day	Year	3. Time of Death 0300 hrs	
)		4a. Facility Name (if not institution	, give street and number)	4	b. City, Tow	n, or Locatio	n of Death		40	c. County of Dea	th	
	Ļ	6813 Red Top Road				Hyattsvi		odes 241 les	. Is Date of B		Prince Georg		
Funeral Director	ι	ınk	5. Sex 7. Ag	ge (In yrs. 1	ast birthday) 7 Yrs.	If Under 1 Months	Days Hou	nder 24Hrs urs Min	_		Fore	irthplace (State or ign ountry) Mali	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	C		Town or Locatio	on						10d. Inside City Limits	
Aaryland 28a-f show 1 at once.	<u>.</u>		Georges	lak	Ollia Park							1 Yes 2 XX No	
with the Maryland ns 23a or 28a-f sho	I Director	10e. Street and Number 6735 New Hampshire				10f. Zip Co 2091	2				izen of What Col Mali		
or iter	Fune	11. Marital Status 1 Never Married 2 XX Mar 3 Widowed 4 Divor	rried 12. Was Deceden Armed Forces 1 Yes 2 rced If Yes, Give Year		If Ye	es, specify C		an, Puerto	pecify Yes or N Rican, etc.)	lo-	14. Race - Ame White, etc.	rican Indian, Black, B1 ack	
atural"	<u>8</u>	15. Decedent's Education (Speci	or Dates:	npleted)	16a. Decedent	s Usual Oca	cupation (Giv	e kind of		16b.	Kind of Business		
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5-003 iled withi Hygiene. I other th	<u></u>	12 17. Father's Name (First, Middle, L	_ast)	-		Laborer		ner's Name	e (First, Middle,		estaurant Surname)		
	<u>a</u> [Bumar Camara							Konate				
MD 12 sho th and 127 is		19a Informant's Name/Relationshi Cheick G. Diakite	ip (Type, Print) Nephew					umber or i apital			ity or Town, Stat 20743		
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Mortant: If item 27 is in injury or other traumatir.		20a. Method of Disposition 1XX Burial 2 Cremation 4 Donation 5 Other Spe		ate Cim	Place of Disposit crematory or othe letier Bame	tion (Name of er place) oko Mal	i i	Feb	Date 18, 2010		Location - City o Bamoko, M		
Balti permit. Departm Imports injury o		21. (9) ature of Funeral Server	The state of the s	/			dress of Faci MORTUAR HWY. S		PORT EN BURNIE	E, MD	21061		
Physician 23a. Part I. Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.										Approximate Interval Between Onset and			
£xaminer	1	Immedi 1. Cause (Final dis a e or conditio resulting in death)	a. Multiple Sharp Due to (or as a cons		<u> </u>							Death	
		Sequentially list conditions,	b		e.							-	
ted Insit		if any, leading to immediate course—Enter Underlying Course (Disease or injury that initiated	С					_				4	
d d ansit		events resulting in death) Last	Due to (or as a cons	equence o	f):								
e executed cian and irial - transi	edical	UNPENDED	AMENDED										
3760 ificate t ig physis the bu		IF FEMALE; 3b. Was decedent pregnant in the	23c. If yes, outco	me of preg		al death	3 Ecto	pic pregna	ancv	23	d. Date of deliver	ry Day Year	
ion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be executed death. roor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burlal - transity of the Commission of the professional for the period of the second of the period of the	ysicia	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at	time of de		er (Specify)		, ,					
ires that the signed by the detache	2	Part II. Other significant conditio	ons contributing to deat	h but not r	esulting in the un	nderlying ca	use given in	Part I.		_		the cause of death? bably 4 Unknown	
v requi	Completed								24a. Wa:	psy	prior to	utopsy findings available completion of cause of	
Reco The law icate has page 2 s	Ę		•							ormed? 2 N	death? 1 ✓ Y	es 2 No	
ital Recician: The scentificate rector, page	a n	25. Was case referred to medical examiner?	[Hospital: 1] lengting	ent 2	ER/Outpatient		Other			Bogida	ence 6 🗸 Othe	or Saana	
n of Vi ding Physi After this funeral dir	2	1 Yes 2 No 27. Manner of Death	28a Date of Inju	Jrv VIL	28b. Time of Inj		Injury at Wo		28d. Describe	how inj	ury occurred	ar. Scene	
ion ttendin death. ttor: A		Natural 5 Pendir 2 Accident Investi		rear)	FOUND: 0251 hrs	1	Yes 2	✓ No	Subject as				
Division of Vital Records, spital or Attending Physician: The law requir tours after death. Ineral Director: After this certificate has been stilled in by the funeral director, page 2 should forbigged to the Commission.	Sertification:	3 Suicide 6 Could determ	not be		ome, farm, street	, factory, off	ice building,		or Town,	State)	and Number or R d, Hyattsville, M	ural Route Number, City	
S 4 1 7	ا ي	(Ondon on)	vsician: To the best of miler: On the basis of exa and manner stated.										
	Ě	29b Signature and title of certifier					.C.M.E.	er			Date signed (Mo	_	
n ./	-	30 Name and address of person w	who completed cause of o	death (Item					_				
3√		Donna M. Vincenti, MD				Penn Str	eet, Baltir	more, M	ID 21201				
Stat Registra	te ar	31. Date filed (Month, Day, Year)	32. Registra	ars Signatu	Barle	20							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 03594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Lillian A. Clem 8, February 2010 1:00 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll County General Hospital Carroll County

9. Birthplace (State or Foreign Country) Westminster 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 245XF Days Hours 224-32-2671 86 August 14, 1923 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 🙀 No Finksburg Carroll County 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 935 Wesley Road 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2€No Specify: Specify. ₩Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker In own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Poseno Cora 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnny Clem 64 Lawson Court York, Pennsylvania 17408 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation] 5 ☐ Other (Specify) Parkwood Cemetery 2/22/2010 Parkville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Burgee-Henss-Seitz Funeral Home, Inc. Baltimore, 3631 Falls Road 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Entry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical **Examiner**

Physician

Examiner

10a. State

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

:: If item 27 is marked other than or other traumatic event.

permit. Page Department of important: if any injury or once.

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Examine the burial-tran Physician/Medical attending p ate has been signed by page 2 should be detacl þ Completed

IF FEMALE:

Hospital or Attending Physician: The law requires that the death certificate be executed ned by the a director, After this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

State

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 MNo 2 **N**o 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northwoods Trail 4231 MD Domingo

31. Date filed (Month, Day, Year) LEE PO WILL Registrar

29b. Signature and title of dertifier

32. Registrar's Signature

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February Cornwell Dadie 2010 6:40 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth Nursing & Rehab Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Feb. 10, 1 M 2 X F Months Days Hours 87 Maryland Yrs. 1923 Director 215-14-4740 be filed within 72 therestend the filed within 72 therestend the filed at arked other than "natural", or items 23a or 28a-f snow arked other than "natural", or items 23a or 28a or Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 1[™] Yes 2 □ No MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Hazlett Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! is marked o မ Joseph John Liberto Rosina DeFatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Rosaria Cornwell 416 Hazlett Avenue; Baltimore, MD 21229 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 2/19/2010 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sterling Ashton Schwab Witzke 22. Name and Address of Facility Sterling ASILON Scr Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that cauded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) denes Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): certificate has been signed by the attending physiclan and lirector, page 2 should be detached for use as the burial-transit CAD that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by OSte o porosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed 2 🗆 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ٩ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at s after death. 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier CRO 2112110 12111615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Goldsberry

31. Date filed (Month, Day, Year)

Jennifer

Division of Vital Records, P.O.

Box 68760

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Francis E. Coleman 10:45 PM February 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, 1 💢 M 2 🗆 F Country)
Maryland 216-16-3322 **Director** 86 Usual Residence of Decedent show. 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4705 Ridgeway Avenue 21206 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White WWII Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Self-Employed Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Coleman Marie Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Pascuzzi/ Daughter 4705 Ridgeway Avenue, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Evans Funeral. 02/17/10 4 Donation 5 Other (Specify) Forest Hill, Maryland Bel Air 22. Name and Address of Facility Evans Funeral 8800 Harford F Signature of Funeral Service Licens Chapel & Cremetion Services Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between iate Cause (Final Onset and Death Physician/ nd-Stre se or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, is Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) (RNP R149194 February 15,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant 701 Charles Towson MD 21204 31. Date filed #Mo 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Man Clark 10:49A M February 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gwynn Baltimore Remoor 1503 Oak Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💢 F 243.46.8835 Month, Day 02 08 Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD GWynn Oak 1 🗆 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7503 Remoor Funeral Road 21207 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Black Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Operator Marbun Zerox 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvev Harris ee Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Clark Remoor Road Gwynn Oak MD 21207 Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Baltimore, MD 02 13 2010 oudon 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallstown ND 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Breast Onset and Death METASTATIC Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Directo for as a nonsequence off The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 4 Pregnant a 9 Unknown i signed by the a ld be detached f Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 1 🗌 Yes Yes e Hospital or Attending Physician: 124 hours after death.
Funeral Director: After this certifical leted filled in by the funeral director, I of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 🗌 Yes 2 **N**O ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗌 Pending Division 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice are:

Certifying Nurse Practice are:

Countries and one of the cause 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-8-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charter drive columbia MD 21044 State Registrar

2 P

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician 2010 /Medical Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner atonsville Baltimore If Under 1 8. Date of Birth **4.** Month, Pay, **7-24 Funeral** Birthplace (State or Foreign Country) 1 □ M 2 ▼ F Months Hours Min Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Experient must be notified at Director 1 Yes 2 00 atonsville Street and Numb 10f. Zip Code 10g. Citizen of What Country? USA Funeral and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementa College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname Be nformant's Name/Relationship (Type. Pr(Grand Son) 19b. Mailing Address (Street and Number or Rural Route Number, City htield Ave., 118 Beec egan, Jr. 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, MD 2-20-10 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LOVANCE DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 X Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) D0061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 EBENEDEN QUAINOD WA WILLGAS AUS # 307 PALTIMORE WAS

Registrar

State

31. Date filed (Month, Day, Year)

≫. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral	9.	5. Social Security Number 6. Sex	7. Age		st birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min,	8. Date of Bir	th w Ye <i>ar</i>	bro	9. Birthp	lace (Stat	te or Foreign
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	and show	or	10a. State 10b. County		10c. City	, Town or Lo	ation							1	0d. Inside	City Limits
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36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 Never Married 2 X Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give		J.S. 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:						etc.) 14. Race - Ame Black Whit ASI Specify: Pac				aland
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Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service License		1016	1 622	. Name and	d Addres	s of Facility	Rot	ert A. 20814	Pu	nphre	y fui	ieral	Home
n	99 E # 9		Kort Kuku	# M	0149	8 B	thesc	ia, i	Mary1	and	20814	• /-))/ N	ISCO	ISIII	Avenue
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	ate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events),										- 1		
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gox	e attel	icia	in the past 12 months? 1 ☐ Yes 2 🕱 No	1 Live Birth 4 Pregnant at	2 ∐ Fetal time of d	death 3 L eath 5 L	Ectopic pr Other (spe	regnancy ec <i>ify)</i>	/				Mo		Day	Year
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IVISION OF VITAL RECORDS,	ng Ph fter th ineral		27. Manner of Death 1	28a. Date of injur (Month, Day,		28b. Time of injury	28	c. Injury work?	at		8d. Describe h					
0	tendii Jeath. tor; Ai the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				М	1 🗆 ነ	/es 2 🗌	-						
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as to complete the funeral director.		4 Homicide determined	28e. Place of Inju building, etc			et, factory,	office			28f. Location (8 City or Tow			er or Rural	Route Nu	mber,
	lospit 4 hour unera ed fille	Medical	29a. Certifier 1 Certifying Physic 2 Medical Examine	cian: To the best of r	my knowle	edge, death o	ccured at ti	he time,	date and p	lace, and	due to the ca	use(s) a	and manne	er as state	d.	manner etator
?	thin 2, the F the F mplet	¥e	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the b	oest of my	knowledge, d	eath occurre	ed at the	time, date	and place	e, and due to th	e cause	(s) and ma	inner as sta	ited.	
	5 ≥ 6 ⊗		29b. Signature and title of certifier	,			290.	License D60						(Month, E)
			30. Name and address of person who col	mpleted cause of de	eath (Item	23a) (Tvne. P	rint)		JJ 7			1 6	Jiuai	., .,		
			Bindu Joseph, M.D					#02	1, Wa	shir	igton,	D.C	. 200	17		

State Registrar 31. Date filed (Month, Day, Year)

FEB 1 6 2010

DHMH 17 Rev 7/2009

State Registrar

Tumara

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 03601 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 0:424 Physician 02 2010 IRVIN D /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE COURTLAND GARDENS PIKESVILLE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year) 6. Sex 1X M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** MD 84 Yrs. 216-20-8852 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show ir than "neturel", or Items 23a or 28e-f shov The Medical Examiner must be notified at 1 ☐ Yes 2 No Director OWINGS MILLS BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 4750 COYLE ROAD, USA #403 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: ģ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pagas 1 and 2 should ba filt mant of Health and Mental Hy tant: If item 27 is marked oth Be BERTHA APPLESTEIN HERMAN COHEN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4750 COYLE ROAD, #403, OWINGS MILLS, MD BRENDA COHEN/WIFE other 20c. Location - City or Town, State 20a. Method ol Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of BALTIMORE HEBREW CEM. BERRYMAN'S LANE permit. Paga Department of Important: If any injury or once. ō 2/14/2010 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lig 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart **Physician** ponger /Medical Due to Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of peath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Hospital: 1 ☐ Inpatient Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Nursing Home 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined after 4 ☐ Homicide within 24 hours a To the Funaral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier 3410 level Ad Baltimore MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIP 7920 Icatts Registrar's Signature 16 State Registrar

DHMH 17 Rev 1/2001

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	Physicia	n/	1. Decedent's Nam	e (First, Middle, Las	st)	60			-	2. Date of De Month	nth Day Year				
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	Director	-	262-22-8 Usual Residence of	435	M 2 □ F 8	9	Yrs.	Months Days	Hours Min.	Dec. 9	ay, Yerg	20 S	outh Carolina		
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	th with ms 23, must	Funeral	2039 Hill	enwood Ro			175	21239			USA				
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status1 ☐ Never Marr3 ☐ Widowed	ried 2 Married 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates.		. 13	. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🕻 No	n, Mexican, Puer	pecity Yes or No to Rican, etc.)	14. Race - Am Black, Wh Specify:				
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212	ed within Hygiene. other tha	Be Co	12		College (1-4 of 3)+)	Line	Operator					Standard		
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	l and 2 s f Health item 27 other tra		Johnnie 20a. Method of Disp	R. Carter	^ / son	20b. Pla	ace of Disc	Hillenwoo position (Name of	1	Baltimo Date	1	MD 2123 ocation - City of			
Baltimore,	4 O - L			Cremation 3 Other (Special	Removal from State (f/)			ematory or other place Forest VA	1	5/10	Owi	ngs Mil	lls, MD		
Balt	permit. Page Department Important: I any injury o		21. Signature of Fu	neral Service Licen	0			22. Name and Addres		l Home	Inc		York Road on, MD 21204		
			23a. Part 1. Enter t	the disease, or com	plications that caused one cause on each line	the death						1005	Approximate Interval Between		
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09/		edica		•	ld. Car	TON	402	athy							
. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗀 Fetal	death 3	☐ Ectopic pregnancy	у			23d. Date of delivery Month Day Year			
P.O.	ires that the dea signed by the a Id be detached f				ontributing to death b		Iting in the	underlying cause give	en in Part I.				to the cause of death?		
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of Vital Records,	sician: The law certificate has birector, page 2 s	Completed by								auto	opsy ormed?	prior to death?	completion of cause of		
tal	ysician: T is certifica director, p	Be	25. Was case referrexaminer?	_/	Hospital:	1 /			ace of Death (Che			· · · · · · · · · · · · · · · · · · ·			
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ion	tending leath. :or: Afte the fun	Certificate:	Natural 2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not b			injury		? Yes 2 No						
Division	al or Att s after d I Direct d in by		4 Homicide	determined	28e. Place of Inju building, etc		ne, farm, s	treet, factory, office		28f. Location (City or To			ural Route Number,		
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2	2 🔼 Medical Exam	sician: To the best of iner: On the basis of e se Practioner: To the	xamination	and/or inve	estigation, in my opinio	n, death occurred	at the time, date	and place	, and due to the	e cause(s) and manner stated.		
	Vith With		29b. Signature and	title of certifier	4			29c. License			-	te signed (Mon			
	1+1		30. Name and addr	ress of person who	completed cause of d	eath (Item	23a) (Type,	Print	17733	2 / 0	TE	nuin	TEN 250		
	V		tatric 31. Date filed (Mont	LIA EUC	Jene 560	0/ L	och	Baven,	Bouleur	and Ba	Hill	nore a	7/239		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland, Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0426 Jamar L. Coates Feb 1, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie **Baltimore Washington Hospital Center** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Months Days Hours Min. (Month, Day, Year) Director Nov 9, 1986 216-13-7227 Marvland Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d, Inside City Limits Director Y Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 335 Addison Drive 21060 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 📮 Never Married 2 🗆 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 nours after 1 ☐ Yes 2 🙀 No Specify: Specify. Black "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Zone Manager other traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cassandra Spencer **Curtis Coates** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau 8200 Durness Court Severn, Maryland 21144 Curtis Coates 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 02/12/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -02/09/10 Pasadena, Md. Mt. Zion Church Cemetery 21. Signatur Tuneral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part shock, or heart failure. List only one Immediate Cause (Final bstructive Physician/ Cardiomyopath disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 Dunknown the detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 2 No 2 1 1 🗌 Yes Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2. No 1 Inpatient 2 KER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural
Accider
Suicide 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATNAKAR MUKHERTEE MD'

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's S

7845 Oakwood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 8:06 PM Robert H. Collins 2/5/2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 431 5th Avenue Brooklyn Park Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 69 236-62-6377 Director 8/5/1940 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show Director MD Anne Arundel Brooklyn Park 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 5th Avenue 21225 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, In. M. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Distillery <u>Supervisor</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Collins Kathleen Remly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Collins / Wife 431 5th Avenue, Brooklyn Park, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/2010 4 Donation 5 □Other (Specify) Loudon Park Cemetery Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. ure of Funeral Service (Toensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, Islaming to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. ed by the 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signe should be o Completed by 1XYes 2 □ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy or Attending Physician: The 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 \sum Nursing Home Medical Certification: To this 1 Inpatient 2 ER/Outpatient 3 DOA 5XResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0064178 and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr; Suite 312, alen Burnie, MD HARVINDER MD SINGH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #768 Per FH G902 4/08/2010 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Francis Joseph Dev1in Jr. 2010 4:56 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 714 Biddle Road Glen Burnie Anne Arundel Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1935 | Months | Days | Hours | Min. | Min. | De c . 26 , 1936 Social Security Number 9. Birthplace (State or Foreign **Funeral** ех Хім 2 □ г 173-28-4148 Director Dec. PΑ Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Anne Arundel Glen Burnie 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 714 Biddle Road 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural". 3 ☐ Widowed 4 🌠 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicaal any injury or other traumatic event, the Medicaal 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cryptologist N.S.A. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Francis J. Devlin Loretta Strittmatter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Dane Devlin /Son 34017 Bob Smith Road Pittsville, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) February 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 17, 2010 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Examiner XSeasO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cor sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death , the & 9 Unknown ed by the signed l ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performe 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. з 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature ay 29d. Date signed (Month, Day, Year) dr ed cause of death (Item 23a) (Type

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month MIT A. DRENNER Mebruary 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MD AHRNEY -KEED BOONSBORD WASHINGTON 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 □ F Days 216-14-8287 85 02/24/1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Boonsboro 1 ☐Yes 2 ☐ No Maryland Washington Co. 10f. Zin Code 10g Citizen of What Country? 10e. Street and Number 53 Sunrise Circle United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 □Yes 2 □No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Humans Relations Specialist Trucking 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Drenner Georgetter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy W. Drenner /Wife Sunrise Circle Boonsbero, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Park 2/16/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALZHEIMERS DEMENTA disease or condition resulting in death) Due to (or as a consequence of): COPD Sequentially list conditions, if any, leading to him adjate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) PROSTATE CANCER Due to (or as a consequence of) HYPERTENSION 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🖺 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

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Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Exercites roust be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If iten 27 Is marked oth any lojury or other traumatic event any lojury or other traumatic event once.

within 72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760

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burial-trans the attending physician the for use as the buria Physician/Medical signed by the a page 2 should Completed certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica r this certificated ral director, p Be Certification: To

funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No

6 ☐Could not be determined

investigation

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29a, Certifier (Check only one)

2 Accident

4 Homicide

31. Date filed (Month, Day, Year)

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Kate in Smith CRUP

R128088

MD 21740

29c. License number

29d. Date signed (Month, Day, Year) 2/12/2010

Kate M Smoth CRNP

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown,

Registrar

Medical



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year 9:45 am volyn Z Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Baltimore Burnie Mrd If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 F Hours 212-28-6656 91 09/09/1918 United Kingdom Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 13th Avenue 21225 United Kingdom 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ 2 No Yes Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3XXWidowed 4 ☐ Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Dodd Kate Clemons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Sharon L. Lewis / daughter 104 13th Avenue, Brooklyn Park, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2/15/2010 Moreland Mem. Park Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. MO1357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 3 days Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death 5 Other (specify) Dav Year Yes 1 Yes 2 = 9 Unknown detached Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 H of Vital Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Tes Other: မ 1 Inpatient 2 -4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) erson who completed cause of death (Item 23a) (Type, Print) Hospital Dr. Olen Bunic, MD 301

DHMH 17 Rev 7/2009

State Registrar sistrar's Signature

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			for State Registrar	State of Mi	ai yiai i		rtificate of		vientai m	Reg. N	2010	03609
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	ysici: Nedic		ALEXANDER DAVIDSON	DEBNAM					Month FEB.	13,	2010 Year	0315 M
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put w			Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation					10d. Inside City Limits
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er dea	METER	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	lo-	14. Race - Am Black, Whit	
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illu XIXIS-0030 be filed within 72 hours after death with the Maryland ntal Hygiene. dother than "natural", or items 23a or 28a-f show	ical E		15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual Occup	oation		16b. I	Kind of Business	s/Industry
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paltiniole, Ivial yla permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke	ier tra		CAROLYN WILLIAMS	МОТН				, BENNETTS	/ILLE, SC	2951	2	
Pages 1 nent of H	or oth		20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3X	Removal from State	20b. P	lace of Dispo emetery, cre	sition (Name of matory or other plac	ce)	Date	20c. l	_ocation - City or	r Town, State
iit. Pa vrtmer vrtant:	njury		4 □ Donation 5 □ Other (Specia		BAY		MATORY INC	<u>-</u>	15, 2010) E	BALTIMORE,	, MD
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			K, GREGORY 23a. Part 1. Enter the disease, or low shock, or heart fail are. It stion by	FINK phrations that caused	MO11 the death			IWY. S., GLE ng, such as cardiac			21061	Approximate Interval Between
Physic	ian		Immediate Cause (Final disease or con vilion	on cause on each III		crh						Onset and Death
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the Hospital or Attending Physician: The law requires that the death certificate be eximine 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician	he bu	ical		d								
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or Att	in by	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju- building, et	ury - At ho c. <i>(Specif</i>)	ome, farm, str y)	eet, factory, office			<i>(Street</i> a own, <i>St</i> ai		Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	pe		29a. Certifier 1 Certifying Pl	ysician: To the best	of mv kno	wledge, deat	h occurred at the ti	me, date and place	and due to th	ie cause(s) and manner a	as stated
le Hos	oletely	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis of and manner st	f examina	tion and/or in	vestigation, in my	opinion, death occu	rred at the time	e, date ar	nd place, and du	e to the cause(s)
To the	comp	Me	29b. Signature and title of certifier	(29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)
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10	V		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type	ersbrg	. MD	217	24		
Re	Stat gistra		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture Ba	NED.	1 1 1 1	- 1			
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AMEND TTEM# 20b, perFH, G900, 2/1672010, ws

State of Maryland / Department of Health and Mental Hygiene 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death F. Month Physician 0=00 2010 /Medical County of Death 4a. Facility Name (If ngt institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 KG | N | F If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Linder 1 Year Year **Funeral** Days Hours Months 1 ☑ M 2 ☐ F Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 벊 1 ☐ Yes 2 No ed other than "natural", or items 23a or 28a-f shevent, the Wedical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0010 Funeral 12. Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WH Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, I'm Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD MARYLAND 21015 MR 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and ddress of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Colon metastatic > 3 month /Medical Due to (or as a consequence of): Examiner Sibrelcetion. Atrial 3 month 5-quarion, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 3 Physician: The law requires that the death certificate be executed month Hypertension sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria disecto months Meart Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been significate page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate 1 ☐ Yes 2 12 No Vital director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) SONS 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours afte To the Funeral Dil completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 13angaria DO065641 MD-2/234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANGORZA, 2314 E. JOPPA Rd. M.D. SUITE-I KAMAL C PARKUILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Beneva S. park

ORIGINAL

DHMH 17 Rev 1/2001

		Plea 1 - State Registrar	se Type or AMEND State o	TTEM#9p		G900 artment o tificate			Mental I	Hygien Reg. N		l 0	03611
Physic /Medi		1. Decedent's Name (First, Middle ALONZO		NIS					2. Date o Month	_	ě	Year 7010	3. Time of Death 4:54a.
Exami		4a. Facility Name (If not institution 2910 Rosaling		mber)				ocation of Dea	ath	4	c. Count	ty of Death	1
Funeral Director		5. Social Security Number 410-20-1771	6. Sex	7. Age (In yrs. Ias 85	t birthday) Yrs.	If Under 1 Y Months D	'ear ays	If Under 24 Hr Hours Min		Birth Day, Yea 15	24	9. Birth Coa	nplace (State or Foreig untry) TN MS
Maryland -1 show	tor	Usual Residence of Decedent 10a. State 10b. County MD NA	4	1	Town or Lo								10d. Inside City Limits
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15-0036 72 hours after death with the Maryland *naturel; or itema 23a or 28e-f show edical Examiner must be nealified at	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 X Widowed 4 Divorced	12. Was Dec	ve			t of His Cuban,		Specify Yes o	r No-	14. Ra	ace - Amer ack, White	rican Indian, s, etc. 3 lack
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	To Be Co	17. Father's Name (First, Middle, Jack Davis						8. Mother's N	ame (First, Mic a Pars				
Ma nd 2 s allth ar 27 is ir trau		19a. Informant's Name/Relations Marie Davis-I				-			Rural Route No.				
Baltimore, permit. Pages 1 a Department of Hea mportant: If Item any injury or othe		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		State		sition (Name natory or othe n For		1	Date 2/17/3				Town, State
Baltimo		27. Signature of Funeral Service	. C. W	un	4		aba	sh Av	e, Bal		ore,	ма	21215
Physician /Medical		3a. Pa 7. Enter the disease, or s ck, or heart failure. List hmmediate Cause (Final disease or condition resulting in death)	complications that conly one cause on a	caused the death. each line. The Care (or as a consequence) The breve	Do not ent Gra / nce of):	er the mode o	t dying,	such as cardi	ac or respirato	ry arrest,			Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate		erehrera or as a conseque		an Disc	ès					-	years
760, e be executed sicien and burial-transit	ai Examin	Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(o a a consequen	15/6_ nce of):								yones
I Records, P.O. Box 687. The law requires that the death certificate atte has been signed by the attending physipage 2 should be detached for use as the 1	by Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregnanc birth 2 ☐ Fetal de nant at time of deat own	eath 3	Ectopic pregr Other <i>(speci</i>						ate of deli	very Day Year
cords, P. w requires that! been signed by should be deta	ed by Ph	Part II. Other significant condition	ms contributing to d		ing in the u	nderlying caus	e given	in Part I.			use cor		the cause of death?
of Vital Records, hysicien: The law requires t his certificate has been signe I director, page 2 should be 0	Completed									Was an autopsy performed?		prior to death?	topsy findings available ompletion of cause of 2 No
0 4 5 6	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manger Penth	Hospital: 1 🗆 28a. Date		8b. Time of	nt 3 DOA 28c.	Other	4 Nursing	Home 28d. Descri	esidence			eify)
Division To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At homing, etc. (Specify)	Injury e, farm, str	М	1 🗆 Ye	es 2 No	28f. Locati City of	on (Street a	and Nun ite)	nber or Ru	ral Route Number,
e Hospitu 24 hours e Funers letely fille	Medical C	29a. Certifier Check only one) Certifyin 2 Medical	g Physician: To the Examiner: On the b and man	best of my knowle asis of examination ner stated.	edge, deatl n and/or in	n occurred at t vestigation, in	he time my opii	, date and pla nion, death oc	ce, and due to curred at the ti	the cause me, date a	(s) and n	nanner as , and due	stated. to the cause(s)
To #: withir To th	Me	29b. Signature and title of certifie	Carl	111 (1	, _			number		1			n, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Zhruary MARSHALL RAYMOND DUGGINS 201 Medical 4a. Facility Name (if not institution, give street and number) **E**xaminer 4b. City. Town, or Location of Death 4c. County of Death Squar OSP 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours Min DEC. 20, 1952 MARYLAND Director Yrs 214-62-9541 57 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2X No MD BALTIMORE ROSEDALE 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 5407 PRINCESS DRIVE 21237 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 Divorced 4 Divorced the Medical Maryland 21215-(16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wift Department of Heath and Mental Hygien Important; If item 27 is marked other to any nijury or other traumatic event, the once. 12 SUPERVISOR SCHOOL SYSTEM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DARRELL RAYMOND DUGGINS EVELYN ARLENE KASE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5407 PRINCESS DRIVE BALTIMORE, MD 21237 MARIA DUGGINS-WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔲 Burial 2 🗓 Cremation 3 🗀 Removal from State 2/12/2010 BALTIMORE, MARYLAND ATLANTIC CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME Signature of Funeral Service Licens 6415 BELAIR ROAD BALTIMORE, MARYLAND 21206 23a. Part 1. Enter the diseas shock, or heart fail Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a constigutince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consumence of). The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-trans and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death the 9 Unknown g 🔲 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 6

Registrar
DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 23a) (Type, Print)

Ah 110 1000 Frank in Solay, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 8 , 2010 February Marie Dreisch Α. 12:00pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6821 Youngstown Ave. Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 218-26-3240 1 □ M 2 🛛 I Italy September 22,1929 Director 80 Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location Director Dundalk Maryland Baltimore 1 Yes 2 XNo 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 6821 Youngstown Avenue 21222 USA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: Specify: White Completed 3 ☑ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "amy injury or other traumatic event, the Meanone." Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Camillo DiBattista Ida DiBattista 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Dreisch son 1406 Delvale Avenue, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Sacred Heart of Jesus Cem. 13, 2010 4 Donation 5 Other (Specify) Dundalk, Maryland Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. S'ynature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lise only one cause on each inc. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a pomosquence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and thoract of the thin the tuneral director, page 2 should be detached for use as the burla-transit Cause (Disease or linjury that initiated events MARLGER Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pendina 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 22 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) E. Blus 2 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03614 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 03 2018 ANE DISCOLLED Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHNS BAYVIEW MEDICA HOPKINS BALTIMORE CANTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛛 F July 25, 1928 219-20-7973 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2502 Ambler Road 21222 USA ral", or items ? | Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 2 XNo 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry ift. Page 1 and 2 should be most artment of Health and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Mundy Helen Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guy J. Di Scuillo Husband 2502 Ambler Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or ot 20c. Location - City or Town, State February Oak Lawn Cemetery 15, 2010 Dundalk, Maryland Donation 5 Other (Specify) Signature of Funeral Service Licensee Onnelly Funeral Home Of Dundalk, P.A. 110 Sollers Point Road, Dundalk, Md. Conne 7110 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respirator disease or condition resulting in death) Medical Due to (or as a cons - ence of): Examiner about 12 hours nvac Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XNo မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural injury work? 5 Pending 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year) KRUDENT HYJIAM 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DY 4940 EASTERN AVENUE DALTIMOKE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) DEMPSTER **Physician** WILLIAM 2010 5:04 P February 2, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Renaissance Gardens 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours 1 ☑ M 2 ☐ F Days Months Yrs New York July 20, 1926 83 **Director** 152-14-4453 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the fix dical Exercities must be nutified at 1 ☐ Yes 2 🛣 No Silver Spring Director Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3126 Gracefield Road Apt# B6427 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give WWII Year or Dates Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Marketing Representative Manufacturing Pages 1 and 2 should be filed vent of Health and Mental Hygid ant: If Item 27 Is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Keene William Dempster ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type. Print) 3126 Gracefield Road #B6427, Silver Spring, Maryland Ann B. Dempster/Wife other 1 Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot February 2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery Westfield, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557/ Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses loy to 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure years Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Chronic Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. 27. Manner of Death Injury at Work? at or Attending P after death. I Director: After d in by the funera Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Records, P.O. Division of Vital To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

Baltimore, Maryland 21215-0036

Box 68760.

Anna Korzan Registrar

29b. Signature and title of certifier

3216 Gracefield Road, Silver Spring, Maryland 20904

ma Konan, MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

February 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 11:00 a^M February 10 Mae Drake Inez /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Cockeysville Maryland Masonic Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🖵 F Yrs 1915 North Carolina Director 214-44-4835 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Cockeysville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21030 USA 300 International Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Baltimore, Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed of Health and Mental Hygiene.

Item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Spence Charles James Richardson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 82112 Ehringhaus Chapel Hill, NC 27517 Mr. Bob Drake/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 2-18-10 Timonium, Md. 4 Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Funeral Service License 1050 York Rd. Towson, Md 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Haye Physician Jeens /Medical Due to (or as a consequence of): Examiner Vasalar Carelino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 | Yes 2 | No 3 | Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 perform certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

3508

David Desabla	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Medical Examine	David William deSabla, Jr. Month Day Year February 9, 2010 0944 hrs
	4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of Death Baltimore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	215-25-4522 1 Months Days Hours Min. Dec. 23, 1980 Foreign Country lary land
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show d at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the 23a or notifie	624 Strandhill Court 21093 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Bace - American Indian Black)
r death with the Maryland or items 23a or 28a-f sh imust be notified at once Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
s after d	3 Wildowed 4 Divorced If Yes (also Year or Dates: Specify: White
"natur Exam	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	12 Chef Culinary Arts
215-0036 be filed within 7 stal Hygiene. *ked other than ent, the Medica Be Comple	
2121 nould be find Mental list marked tic event,	David W. deSabla Diane Frances Gayhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 3	Diane F. DeHaven / mother 624 Strandhill Court; Timonium, MD 21093
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 \(\hat{\lambda}\) Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimo permit. Page Department of Important: injury or ott	4 Donation Other, Specify: Hilltop Service Corp. 2/15/10 Towson, MD
Balt permit. Departi Import	21. Signature of Funeral Sent Cellicensee 22. Name and Address of Facility 1050 York Road
Physician	Ruck Towson Funeral Home Towson, MD 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and
(Examiner	Immediate Cause (Final disease a Cocaine intoxication with opiate, benzodiaze ine and Death
.'	or condition resulting in death) Due to (or as a consequence of): alcohol use Sequentially list conditions, b.
iner	if any, leading to immediate Eule to (or as a consequence of).
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
E Tra	X UNPENDED X AMENDED 23a, per ME g901 3/23/10 TT
~ o .o.⊏ 1 23	X AMENDED 23a, per ME g901 3/23/10 TT 23a, 27, 28a-f, permE, g901 3/9/10 TT 23c. If yes, outcome of pregnancy 23d. Date of delivery
68760, ertif cate be ding physici e as the buritien/Med	23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
	1 Yes 2 No 9 Unknown Unknown Unknown
Records, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for u Completed by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ds, F quires en sign uld be	1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requires as after death at Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed	autopsy prior to completion of cause of performed?
tal Rec tian: The l certificate l ector, page	1 Yes 2 ✓ No 1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one)
Vital I hysician: this certifi I director,	examiner? 1 V Yes 2 No Hospital: 1 V Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:
on of Vital I dding Physician: the After this certifi e funeral director, ion: To Be C	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ivisior or Attenc after death Director: I in by the tificatic	2 Accident Fd 2/7/10 Fd 1:00 am 1 Yes 2 A No OTTR
Division o spital or Attending ours after death neral Director: Aff filled in by the fund Certification:	Suicide 6 X Could not be determined (Specify) Wisp Ski Resort (Specify) Wisp Ski Resort McHenry, MD
5 ~ = S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
To the Hi within 24 To the Fi completel	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
, -	O.C.M.E. February 12, 2010
OK perd	30. Namand address of person who completed cause of death (Item 23a)
	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	31. Date filed (Month, Day, Year) Segistrar's Signature August
DHMH 17 Rev 1/2001	OCINE ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical Month Ellison 0600AM anice Febru 102010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 50 Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1 M 2 Days 59 Director <u>212.56</u>.3162 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE Wilmington 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 19806-314 Funeral 1625 Gilpin Ave. Apt. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Janie unk ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towanda Taylor/Niece 513 Crownwood Ct., Edgewood, MD 21040 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2☐ Fermation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 02.13.10 Beltsville, M 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto., MD 21286 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Hospital or Attending Physician; The law requires that the death certificate be executed pathic that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Hospital 2 No ပ Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Accident Injury 1 🗌 Yes 2 🗌 No I Director 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, officè building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Funeral Detely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) RES-OCO

Registrar DHMH 17 Rev 1/2001

State

Hishley

31. Date filed (Month, Day, Year)

ORIGINAL

Name and address of person who was letted cause of death (Item 23a) (Type, Print) Huldeson, MD

32. Figistrar's Signature

February 10, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 035 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A M 2010 10 Medical Facility Name (if not institution, give st City, Town, or Location of Death **Examiner** 4c. County of Death amar Social Security Number 8. Date of Birth

(Month, Day, (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 M M 2 🗆 F Yrs. Director inginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 6000 212 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced B/ack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) abires Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ည aunce 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ear 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee and Address of F 2121 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SURARACHNOID HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, from Scause Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No been signed by the should be detached 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural nours after death.
neral Director: Aft 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 3,2010 058133 M.D. ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person KERITH M.D. 5601 BLVD BALTIMORE, MD 2123 LOCH RAVEN 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of 4c. County of Death outh 11 8. Date of Birth
(Month, Day, Year)
7, 1949 24 Hrs. Min. . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Country) 214-56-1236 60 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other trammatic event, the M. disal Examiner must be notified at 10a, State 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 No Glen Burnie 10f, Zip Code 10g. Citizen of What Country? Funeral 4 South Meadow Drive 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1X Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Proof Reader Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard F. Emery Alice H. Hannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Richard F. Emery/Father South Meadow Drive Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 20, 2010 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MOY121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician teriose Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) Examine fran, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day the P.O. ģ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗆 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident М Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DEPHTY Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ELDRIDGE WILLIAM 8,2010 8:57 Ρ February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore 9937 Maidbrook Road 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours Min 80 213-26-9563 Feb. 24, 1929 New Jersey Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 🙀 No MD Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9937 Maidbrook Road 21234 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. white Specify 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Welder 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wallace Eldridge, Sr Alberta Shelhorn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Elridge-son 2609 Plainfield Road-Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel and Cremation-Belair 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 endia o 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) et Mor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 KNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examine the death certificate be execute sician and burial-trans P.O. Box 68760, attending physician as the nse for signed by the a d be detached for icate has been si; page 2 should b certificate this

Physician

Examiner

/Medical

Physician/Medical Completed Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

9

Completed

Be

ဂ

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evanther must be notified at once.

Julian, Eldridg

Baltimore, Maryland 21215-0036

1 Natural 2 Accident 3 Suicide

4 Homicide

Charles

29a Certifier

Medical

State Registrar

Division of Vital Records, within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Attending the Hospital or

rada et Mo 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 ☐ Could not be

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Pada ett MD, 5601 Loch Raven

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore Mb 21239

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death Physician/ Month Medical Examiner 4b. City, Town, or Location of Death Ac. County of Death Rai HMOVE 9. Birthplace (State or Foreign Country) **44 Funeral** 8. Date of Birth Months Hours Min. (Month, Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Funeral Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? renwood Avenue USA 21212 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 ☐ Divorced Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industr (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ sillie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ulenbarr Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o Burial 2 Cremation 3 Removal from State Battimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Medical Onset and Death DVLMENOY
Due to (or as a consequence of): FIBROSI disease or condition resulting in death) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Later Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown the 1 ☐ Yes ≥ 1 9 ☐ Unknow I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 06streny 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? Yes 2 No director, page 2 1 Yes 2 No 25 Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPI Hospital: 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending М 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) and title of certifier 29d. Date signed (Month, Day, Year) 2010

DHMH 17 Rev 7/2009

State Registr<u>ar</u> AARON

31. Date filed (Month, Day, Year)

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Charles

TON SON

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature.

(HYVLUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g900 2-16-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY Bay HFI FNF EISNER 2017 7:38 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ARDEN COURTS PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕻 F 3/23/1932 215-28-4119 77 Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 Yes 2 No BALTIMORE PIKESVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3407 MANOR HILL ROAD **Examiner must** 21208 USA 12. Was Decedent Ever in U.S. Armed Force 1 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or þ 72 hours after Maryland 21215-0036 1 🗆 Yes 2 💆 No Specify: Specify: Completed 3 Divorced 4 Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) filed within **EXECUTIVE SECRETARY** WHOLESALE FLOORING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be 1 NATHAN HANKIN FANNY KATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3407 MANOR HILL ROAD, PIKESVILLE, MD ALLEN EISNER/HUSBAND Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Page 1 any injury or BETH TFILOH CONG. $2/\frac{10}{10}/2010$ BALTIMORE 4 Donation 5 Other (Specify) ure of Euneral S Nice Licen ee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediat cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a nonsequence off the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy erform certificate Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ASSISTED LIVING Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Spe 2. No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52 th 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Valley (IMONIUM) 2300 Wright MI) Ernestine laney 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 1 6 201 Registrar

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R ZE

10-00912 John England Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Trems 5-70b per the 9900-02716/10dbb

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hn England		State of Maryland / De Amend Items 5,20b per	th g900	, D2716710	dhb	rrygiene		201	0 03024
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ical Examine	er	John Burnell England					iary 1, 20	c. County of Deal	
	4	a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of L	eath	ľ		
		University Hospital		Baltimore				N/A	irthplace (State or
Funeral	5	5. Social Security Number 214-17-9284 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 2 Hours	Min		Fore	ign
Director	-	214-17-9284 219-06-6104 1XM 2 F 2'	7 Yrs	Months Days	Hours	8/3	0/198	32 c	ountry) Md.
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any	_	10a. State 10b. County 10c. C	City, Town or Locat	ion					1 X Yes 2 No
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Maryland 28a-f show 1 at once.	ᇎ	10e. Street and Number		10f. Zip Code			10g. C	itizen of What Co	untry?
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed	12 17. Father's Name (First, Middle, Last)		1110 112	18. Mother's	Name (First, N	Middle, Maid	en Surname)	
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu matic event, the Medical Examiner must be notified at once	라	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	et and Numb	er or Rural Ro	ute Number	, City or Town, Sta	ate, Zip Code)
MD 3 d 2 shou lith and I n 27 is	-1	Denise Drake England	3809	Roland	lview	Avenu	ie,Ba	1timore	, Md. 21215
and 2 and 2 icalth tem 2 trau		20a Method of Disposition	20b. Place of Dispo	sition (Name of ce	metery,	02/09/	2010	c. Location - City	or rown, state
Ore ges 1 rof H ither	- 6	1 X 8urial 2 Cremation 3 Removal from State	oodlawn		27.77	$\frac{2/8/20}{2}$) 10 B	altimor	re, Md.
timent trant	J.	4 ponation 5 Other Specify: W 21 Signor re of Funer Service Lice ee	r 2	Name and Address					
Baltimore, MD 21215- permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the	k	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	H G	Rute	TQ W	ace. Ba	a.Itim	ore.Ma	21211
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Physician /Medical	- 1	fakire. List only one cause on each line.							Death
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68 certif	iai	past 12 months?	C de ethe	Other (Specify)					
SOX leath e atte for u	Physician/M	1 Yes 2 No 9 Unknown g Unknown							e to the cause of death?
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Vital Records, hysician: The law requir this certificate has been stated to the law required that the law required to the law required to the law recent that the law	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient	2 FR/Outpati		Other ₄	Nursing Hom		esidence 6	Other:
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. The law requires that the attending physician is certificate has been signed by the attending physici rely filled in by the funeral director, page 2 should be detached for use as the burinely filled in by the funeral director, page 2 should be detached for use as the burinely many page 2 should be detached for use as the burinely many page 2 should be detached for use as the burinely many page 2 should be detached for use as the burinely many page 2 should be detached for use as the burinely many page 2 should be detached for use as the burinely many page 2 should be detached for use as the burinely many page 3.	To	1 ✓ Yes 2 No	28b. Time		ijury at Worl	? 28d. I	Describe ho	w injury occurred	
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Sion tittend death ctor:	ati	2 Accident Investigation 28e. Place of Injury	At home form 5	treet factory office			ocation (Str	eet and Number of	or Rural Route Number, City
ivisior or Attend after death Director:	≝	3 Suicide 6 Could not be 28e. Place of injury		it cot, tactory, since			or Town Sta	ite) hroe Street, Bal	
Dital ours a	Certification:	4 V Homicide determined (Specify) Local			date and n				
Hos 24 h e Fur			nowledge, death of lation and/or invest	igation, in my opini	ion, death o	ccurred at the t	time, date a	nd place, and due	to the cause(s)
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner: On the basis of examinar and manner stated.			ense number				(Month, Day, Year)
- 2 - 3	Ž	29b. Signature and title of certifier			C.M.E.			February 2, 2	2010
		After Braney, My			J.171. L.				
		30. Name and address of person who completed cause of dea	th (Item 23a)	1 Penn Street	Raltimo	re MD 212	01		
		Melissa Brassell, MD Assistant Medical E			, Daimino				
	tat		Signature 4						
Regis	316		98						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene fh. 2905,07719/2010dhb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** JOSEDIA taring 16:13 PM Feb 12 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** HOWARD Howard County General Hospital Howard County Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1x M 2□ F Months Yrs. **Director** 307-34-0408 Usual Residence of Decedent 05/09/1934 Anderson, Indiana 10c. City, Town or Location 10a. State Anne Arundel 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the tradical Evandral must be notified at Funeral Director 1√Yes 2 No MD Howard Jessup 10e. Street and Number
1605 Colesbury Place 10f. Zip Code 10g. Citizen of What Country? death 1605 colesburg Jessup

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) US Was Decedent Ever in U.S. Armed Forces? 1. ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be flied within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evandrat once. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Magician Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Gunder Peter Farina ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Colesbury Place 1605 Golesburg Place Jessup MD 20794 Peggy A. Farina
20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Fernation 3 Removal from State 4 Donation X5 Other (Specify) Ardent Cremations 2/16/2010 Hanover MD 21. Signature Funeral Servic Licens 22. Name and Address of Facility Hanover MD 21076 Ardent Cremations 7522Connelley Dr. SuiteN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Man Ms AFFER Loconon /Medical Due to (or as a consequence d) Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetes Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of). Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate I funeral director, page Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner≀ 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending MA spital or Attendi lours after death. neral Director: A investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 12 2010 MO 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print) Klemanh Phain Cedar Lane 21044 5755 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Fisher 0:35 PM Gary Victor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/14/1945 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Days Hours Pennsylvania 64 Director 230-60-5322 Usual Residence of Deceden and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown Washington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21740 1230 Hunters Woods Drive 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married X Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Operations Manager permit. Page 1 and 2 should be file.
Department of Health and Mental Hw.
Important: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothea McClintock Donald R. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1230 Hunters Woods Drive, Hagerstown, MD 21740 Billa Fisher / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 02/15/2010 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry Signature of Funeral Service Lice 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physiciani myocardia Medical resulting in death) Due to (or as a consequence of) **Examiner** 51 (3509 Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months Month Vear Pregnant at time of death 2 10 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? (avin an 24a. Was an has autopsy performed echole 2 No 1 🔲 Yes 25. Was as referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral direc 2 400 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ NO Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Smill Deser 4006111 2009 25(30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Otate of IV	iai yiai k	,	rtificate			and ivid	orital Try		20	10	03	627
	Physicia		1. Decedent's Name Rubin Fal		st)							2. Date of De Month Cebrua	eath [TV	10,	Year 2010	3. Time 7:4	of Death 3 a _M
	Medic Examin		4a. Facility Name (if n	_				,		r Location of	f Death			tc. County	of Death		
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	Director		125-18-82 Usual Residence of D	.54	⊠ M 2 □ F	91	Yrs.	Months	Days	Hours	Min.	Month, D. 2/16/1	ay, Year, 918)	Count		- Or Foreign
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	s 23a or uust be n	Funeral Director	10e. Street and Numb 8505 Spri		Road			10f. Zip 209	910				10g. 0	SA	Vhat Coun	try?	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marrie 3 🙀 Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Was Decede If Yes, speci			jin? (Speci , Puerto Ri	fy Yes or No can, etc.)			e - America k, White, e Whi	etc.	
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Baltimore, Maryland 21215-0036	age 1 ar ent of He nt: If iter y or oth		20a. Method of Dispo		Removal from State	, ce	ace of Dispo metery, crer sapeal	natory or ot	ther plac		Da /13/2		1	Location -	-		
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			23a. Part 1. Enter the shock, or heart	e disease, r com failure. List only o	plications that cause ne cause on each lin	d the death								, rib .	20710	Approxim	nate Between
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8760	rtificate ing phy e as th		IF FEMALE:														
Box 6	Attending Physician: The law requires that the death certifure are death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/	23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic p Other (spe	oregnanc ec <i>ify)</i>	су				23d. Dat Mor	te of delive	ry Day	Year
P.0	that th	by Pr	Part II. Other signific	cant conditions o	ontributing to death	but not resu	llting in the u	underlying c	ause giv	ven in Part I.				use contr			
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Division of Vital Records, P.O.	I or Attenc after death Director: ,	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of In	ury - At hor c. (Specify)	ne, farm, str	eet, factory,	, office		28	Bf. Location (City or To			er or Rural	Route Nui	mber,
ı	e Hospital or Att 124 hours after de Funeral Direct leted filled in by t	Medical	(Check 2	Medical Exam	sician: To the best o	examination	and/or inves	tigation, in m	ny opinio	on, death occ	curred at th	ne time, date	and plac	ce, and due	to the cau	ise(s) and r	manner stated.
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P.O. Box 68760, of Vital Division

Maryland

Baltimore,

within 24 hours a 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JO MARTIN RESIDENT PHYSICIAN 1013142116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JO MARTIN, MERCY MEDICAL CENTER 301 ST. PAUL PLACE, BALTIMORE MD 21202 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

2/10/10

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 4:35AM Farrar FFB 09 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In rs. last b If Under 24 Hrs. 1 □ M 2 🔀 F Months Days Hours 231-36-9400 80 Virgínia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No N/A MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1714 Aberdeen Road 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Retail Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sally Judge В. Farrar Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Scott (Daughter) 1714 Aberdeen Rd., Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cem. 02/18/10 Marriotsville, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EPSIS disease or condition resulting in death) Due to (or as a consequence of) PHEMONIA Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of): Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES, GLOUT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ANEMIA autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident

Physician /Medical Examiner Examiner

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r than "natural", or items 23a or 28a-f show the Mudical Ecominer must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Magnobe.

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3 Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of certifier

physician for use as the the þ has certificate this

Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral i Hospital or

State

31. Date filed (Month, Day, Year)

SATISH KABRA,

6 ☐ Could not be



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

atish Kabia MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

FEB 09 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decede t's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner dallstour tospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign-Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs 1 M 2 DP Months Hours 247-38-0792 Carolin Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examinant Local Control of States and Examinated and Examinate 1 ∏yes 2 □ No Director It mou 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo ac Specify: 3 Widowed 4 ☐ Divorced "natural" Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Monee. Elementary/Secondary (0-12) College (1-4or 5+) embler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ nson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aue lto nomas Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State ('lehany 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Lic MD 2120 Ho 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence P 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specif 27. Manner of Death 28b. Time of Injury 28a. Date of Inj 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation 1 ☐ Yes 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month

FEB 16

DHMH 17 Rev 1/2001

ORIGINAL

(Item 23a) (Type, Print)

Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ethel Beatrice Fauth 01:52 A /Medical 13 2010 4c. County of Death 02 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Director 212-32-0715 Usual Residence of Decedent 08/09/1931 Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No Baltimore MD Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7218 New Cut Road 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaking Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Elmer L. Clayton Ethel Mast 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 stands of Health a. Important: If Item 27 is any injury or other trauonce. (daughter) 7222 New Cut Road - Kingsville, Maryland 2
20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Joanne Parr 21087 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fork U.M. Cemetery 02/17/2010 | Fork, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee assahn 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 bhknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 NO Vital 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Impatient 2 ER/Outpatient 3 DOA Division of this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, SUITE 21/22B, BELAIR, MD 21014 DANUSIAA SIMITHAR 60 CATEWAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stephanie Funk		I- For State	Sta	te of Maryla	and / D		ent of			•	giene	24	111	03633
Physician		Registrar 1. Decedent's Name (Firs	t, Middle,	Last)					-		2. Date of Dea		210	3. Time of Death
Medical Examine	er	Stephan	ie	Fun					_		Month February		ear	0714 hrs
		4a. Facility Name (if not in 7309 Forest Ave		give street and nu	mber)		4b	. City, Town, or L Hanover	ocation of D	eath		4c. County Anne A		
Funeral		Social Security Number		Sex	7 Age (In	yrs. last birth	nday)	If Under 1 Year	If Under 2	4Hrs	8 Date of Bir			thplace (State or
Director		217-64-7165		M 2XF	,,,,ge (52	Yrs.	Months Days	Hours	Min.	02/10	,	Foreig	
	ŀ	Usual Residence of Dece		IVI ZZXII			113.				02/10	1 1 7 3 ,		
v any	ſ	10a. State 10b. 0	County		10c.	City, Town	or Location	n						10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marked of the man "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Elineral Director		10e. Street and Number 7309 Fores	t Av	enue				10f. Zip Code	1076		1	Og. Citizen of V United		-
with th	<u>.</u>	11. Marital Status		12. Was Dec	edent Ever	in U.S.	13. Was	Decedent of Hisp		(Spe	cify Yes or No			ican Indian, Black,
or items 23	nue	1 Never Married 2	Marr	ied Armed Fo	orces?	No	If Yes	s, specify Cuban,	Mexican, Pu	erto R	ican, etc.)	Whi	ite, etc.	
s after iral", o				or Dates:				/x.4x	specify:				Whi	
hours "natu	<u> </u>	15. Decedent's Education Elementary/Secondary		only highest grad		ed) 16a. D		Usual Occupationst of working life. I				16b. Kind of B	usiness/	Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		Liomoniaryroccoridary	(0 12)	4	40101)		Regi	stered N	lirca			Heal	thea	re
5-0(led wi fygier other		17. Father's Name (First, I	Middle, La				ICET			ame (f	First, Middle, M	Maiden Surnam		10
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		Donald La	nder	7 - 577.		Lage			Cat					
ID 21 should and Me 7 is man	- 1	19a. Informant's Name/Re			1		_	Address (Street				, - ,	,	, -,,
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nor ages I mt of I other	١	1 Burial 2 X Cre					ry or othe			2 / 1	0/2010	Clam	D	d o MD
Baltimore, MD seemit. Pages I and 2 sho peartment of Heath and Disportment of them 27 is njury or other traumati	h	4 Donation 5 Of 21. Signature of Funeral S	ervice Li	ensee		Atlant		rematory me and Address o				Glen		Cremation
	1	M.S.	VC	. 7/	M01		Ser	vices PA	; 1 2	nd .	Ave SW	; Glen	Burn	ie,MD 21061
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		Gilden Gilly		sician: To the best										
To the Hos within 24 h To the Fur completely		one) 2 Medic 29b. Signature and title of		ner:On the basis of and manner st		ion and/or in	vestigatio	29c. License		ed at t	he time, date a			
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		30. Name and address of	person wh	no completed caus		(Item 23a)		0.0.141					,	
Ø √		Ana Rubio MD.		tant Medical E			enn Str	eet, Baltimor	e, MD 21	201				
State	е	31. Date filed (Month, Day	Year)	2010 32. Re	gistrar's Si	gnature	1							
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item 20b per th g900 2-16-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY Physician/ 2010 BONNYE FRIEDMAN 10:21 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE 130 SLADE AVENUE, #103 PIKESVILLE Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 1 M 2 X F Hours 1270671951 219-58-5718 Director 58 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilth and Mental Hygiene. Important: If item 27 is marked of wher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 130 SLADE AVENUE, #103 21208 USA . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 X Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EDWIN **EISENBERG** SONDRA KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN EISENBERG / BROTHER 12603 WATERSPOUT COURT, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2010 MOSES MONTEFIORE CEM. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee 1autt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Metastatic disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to or as a conse gience of Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live. ...

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 2 🗭 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who completed gause of death (Item 23a) (Type, Print)

I 13 0 10 2835 V Smith Are Suite 203 Battimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of M		artment of Health and tificate of Death		21111 113635
		Decedent's Name (First, Middle, Last)		inoute or Bount	2. Date of Death	3. Time of Death
Physic Med		Donald Charles F	aber		Month February	Day Year
Exam	ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death
<i></i>		5 Belfast Road [5. Social Security Number	je (In yrs. last birthday)	Timonium If Under 1 Year I If Under 24 Hrs	8. Date of Birth	Baltimore
Funera Directo		187-07-9905 1 ½M 2 □ F	89 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country) Pennsylvania
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arylan a-f sh fied a	Director	Md. Baltimore	10c. City, Town or Loc Timonium			10d. Inside City Limits 1 ☐ Yes 2 反 No
the Mis or 28.			TIMOTITUM	10f. Zip Code	10	Og. Citizen of What Country?
with the s 23a ust b	Funeral	5 Belfast Road		21093		USA
death item ner m				Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian,
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never	No	☐ Yes 2 🙀 No Specify:	,	Black, White, etc. Specify: White
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imore Page 1 au nent of H ant: If ite ury or oth	П	20a. Method of Disposition 1 □ Burial 2 😾 Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Date 2	20c. Location - City or Town, State
₩ 2 4 4 5		4 Donation 5 Other (Specify)	Hilltop S	Service Co. 2-1	7–10	Towson, Md.
Baj permij Depar Impor any in		21. Signature of Furthral Style Licensee	22.	Name and Address of Facility Ruck Towson F 1050 York Rd.	uneral Ho	me, Inc. Md. 21204
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each line	d the death. Do not ente	r the mode of dying, such as cardia	or respiratory arres	t, Approximate Interval Between
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1	xamination and/or investi	gation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.
To the To the Comp		29b. Signature and title of certifier	Mille	29c. License camber		d. Date signed (Month, Day, Year)
		30 Name and address of person who completed gauge of d	eath (Item 23a) (Type, Pr	RAYD 23141	6	0-19-10
10+1		UN 7505 OSTER	Dr. 214	Towson	MD	21204
Sta Registi		31. Date filed (Month, Day, Year) 32 negistre	ar's Signature	ak D		

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Certificate of Death

Reg. No For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb 2, 2010 Month 12:15a Gracie Felder Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 922 Ashburton Street If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 11, 1938 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F So. Carolina Director <u>247-62-2583</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 1 Yes 2 No Maryland Baltimore N/A ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 922 Ashburton Street 21216 U.S.A. items 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 9 Completed by permit. Page 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any njury or other traumatic event, the Medical Examinane. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Black 3 □wWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Azalee King Johnny Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Ashburton Street Baltimore, Maryland 21216 Deonta Lansy 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place 02/11/10 Catonsville, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 1300 Futaw Place, Baltimore, MD 2121 Gasch's Funeral Home, PA Hyattsvil 21. Signature of Funeral Service Lice Firt 1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ascular disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause Eller Underlying Cause (Disease or linjury Due to (or as a consequence of): Examin the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year Day signed by the a 1 ☐ Yes ∠∠ 9 ☐ Unknown Unknown 1 by t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No Yes 2 No **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) the Hospital or Attending 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Datę signęd (Month, Day, Year) 2 DA7683 3/10

State Registrar

31. Date filed (Mon

Raymond

Miller

muli

2835

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith

Registrar's Signat

Ave

Smk 203

Balhmore

MO

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month () Z Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Medical N/A enter Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Country)
Virginia (Month, Day, Year)

May 8, 1925 1 🖳 M 2 🗆 F Days Min Director 224-20-9296 Usual Residence of Decedent 28a-f shov 10a. State be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3331 West Belvedere Avenue 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. 9 Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify. Black "natural" 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Revere Copper Company Fork Lift Operator Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event any io. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lettie Fenwick James Fenwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3331 West Belvedere Avenue Baltimore, Maryland 21215 Ruby Fenwick 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/18/10 Owings Mills, Md. Garrison Forest Veterans Cerhetery . Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutow Place Baltimore, Md 21 Part 1. Enter the disease, or complications that caus shock, or head failure. List only one cause on each li d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immodate Cause (Final Onset and Death Physician/ TEUSION disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any localing to in modal cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Gallbladder Cancer Metastatic or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 cate has to 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: ျှ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred I Director; After to ad in by the funeral 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after o e Funeral Direct determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Year Griggs 00 A es/ex DIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE 5615 Brookly ARK TSUNDE Birthplace (State or Foreign Country) If Under 1 Year If Under 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 24 Hrs. **Funeral** Days (Month, Day, Year, 1 X M 2 🗆 F 218-42-64 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Burnie 1 Yes 2 No MARYMAND 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 660 21060 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced NAVY Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Sister to IZINGER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cre 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State GKN BUTHIE 20-2010 4 Donation 5 Other (Specify) 21. Signature of un ral Service Licenses Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final nset and Death Physician/ esophagea disease or condition Medical resulting in death) Due to (or as a conse serince of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-transit Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) or Attending Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifie 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 02-16-2010 Wennus as 325 (reene St Bouthmare, no 21201. Pers

Registrar

State

31. Date filed (Month, Day, Year)

FEB 16 2010

√32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Gallatin Jean 1:38AM 0 رول /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner rastal Hoopic at Julisbur If Under 1 Year If Under 24 Hrs. cigues 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 578–68–7869 **Funeral** Months Days Hours Min. 1 ☐ M 2 🗓 💥 90rs. Director 08/18/1919 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County if than "natural" or Items 23a or 28a-f show the Medical Examples must be realthed at Berlin Director MD Worcester 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 Meadow Street Apt 220 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Depa tment of Health and Mental Hygiene. Important: If item 27 is marked other than "ranging any injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Government Secretary 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Gallatin Anna Lehne ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Burda / Cousin 534 5th Avenue, East McKeesport PA 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State McKeesport-Versailles Cem 2/19/2010 McKeesport, 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Charles L. Stevens Funeral Home, I 1501 E. Fort Avenue, Baltimore MD 21. Signature of Funeral Service Licensee Victor P. Doda ोटि 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) **Physician** PARKINSON DISTEASTE /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed buriel-trar Due to (or as a consequence of): P.O. Box 68760, signed by the attending physiclan be detached for use as the burie Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2☐No 24a. Was an s certificate has I lirector, page 2 s autopsy perfo rmed?> 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; if 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PLC12 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? - Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Human 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death Rea. No 1. Decedent's Name First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 nar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL BALTIMORE N/A 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year __ If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2-6-193 1 √M 2 □ F Months Days Hours 79 216-24-9529 Director MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE ROSEDALE 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1610 ROSEWICK AVENUE 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 X Married 1 Yes 2 ☐ No 1 Yes, Give 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates. 1951 -55 or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) CLASS A Elementary/Seconday (0-12) 1 0 College (1-4 or 5+) **BETHLEHAM** STEEL MILLWRIGHT Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **GAJEWSKI** THOMAS HELEN (FABESAK) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERA MAE GAJEWSKI/WIFE 1610 ROSEWICK AVE ROSEDALE, 21237 timore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 2-13-2010 GARDENS OF FAITH BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) FNTOMEMENT Signature of Fund 3 ance Licer ee 22. Name and Address of Facility 1 2 1 1 CHESACO AVE BALTO, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Secuentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a cons attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Impatient 2 | ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 No Accident Investigation filled in by the Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and Ittl of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

		For State Registrar	State of Ma		rtificate of	Health and I <i>Death</i>		g. No. 2 () (0361
Physici Medio/		1. Decedent's Name (First, Middle, Last	oilmore		- Inouto or		2. Date of Death		3. Time of Death
Examin		4a. Facility Name (If not institution, give University of Mari	street and number)	lical Center	A	r Location of Death more, MC	7	4c. County of Deat	h
uneral irector		5. Social Security Number 6. Security Number 219–18–6838 Usual Residence of Decedent	x 7. Age □M 2 F	(In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 27	Yea <i>r)</i> 9. Birt 1922 M	hplace (State or Fore untry) ARYLAND
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination must be untified at	rector	10a. State 10b. County MARYLAND N/A 10e. Street and Number		10c. City, Town or Lo	BALTIMOR	E	10	g. Citizen of What Co	10d. Inside City Limi NXYes 2□N
nust be	Funeral Director	2405 TERRA FIRMA	RD. 12. Was Decedent E	over in II C 12	2122.			U.S.A.	
marked other than "natural", or items imatic event, the Medical Examinar in	[<u>\$</u>	11. Marital Status 1 □ Never Married 2 □ Married 3XXWIdowed 4 □ Divorced	Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates:		was becedent of r If Yes, specify Cub 1 □ Yes 2\lambda \text{No}	Hispanic Origin? (S) an, Mexican, Puerto Specify:	o Rican, etc.)	Specify: BL	e, etc.
than "natu e Medical	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed) College (1-4or 5+	(Give		during most of world)	king	6b. Kind of Business/	,
ked other I	To Be Co	12th grade 17. Father's Name (First, Middle, Last) JOHN FREDERIC	ע	FOO	D SERVIC	18. Mother's Nam	ne (First, Middle, Ma	,	TY_SCHOOLS
27 is marl r traumati	Ĕ	19a. Informant's Name/Relationship (7) Myron Gilmore/Son	vpe. Print)	i	-	and Number or Ru		CK City or Town, State, 2 ville, GA.	
Important; If item 27 i any Injury or other tra once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	CERY 02-2	Date 20	Oc. Location - City or	Town, State
Important; I any Injury o once.		21. Signature 1 Funeral/Service Licens		W W	2. Name and Addre		MMUNITY F	UNERAL HO	
sician edical miner	iner	23a Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. Pulmor Due to (or as a b. End St	F/	er the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
bur	dical Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
D 88	/Me	IF FEMALE:		of pregnancy				23d. Date of del	
by the attending physic ached for use as the b	hysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 [☐ Ectopic pregnand ☐ Other (specify) _	су		Month	ivery Day Year
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r: After this certificate has been signed by the ne funeral director, page 2 should be detached	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	1 Live birth 2 4 Pregnant at 9 Unknown Intributing to death bul Hospital: 1 Inpatier 28a. Date of Injury (Month, Day,	2 Fetal death 3 I time of death 5 [t not resulting in the unit 2 ER/Outpatient y Year) 28b. Time of Injury Ty - At home, farm, str	Other (specify) _ nderlying cause given nt 3 □ DOA Other f 28c. Inju Wor M 1 □	ven in Part I. 26. Place of Dea ler: 4 □ Nursing H	1 Yes 24a. Was an autopsy performs 1 Yes 2ft (Check only one) ome 5 Residen 28d. Describe how	Month acco use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes acc 6 Other (Spering occurred)	the cause of death obably 4 I Unknown topsy findings availation of cause 2 No
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171 State Registrar

Rayh J. Lebron MD 225. Greene St. Baltimore, MD

31. Date filed (Month, Day, Year)

FEB 16 2010 Runn B. Sand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ~ Month Physician epruari Brenda Green /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore neral If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/27/1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 H F Days Hours Yrs Director 220-38-5844 68 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Wedical Examiner must be notified at 1 TYes 2 □ No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 Funeral 5625 Frankford Avenue Apt.C2 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 No Specify. δ Specify: 3 HWidowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Its once. 6 years Nurse Liberty Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William ဂ္ Dorsey Sr. Veronica Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Twila Terrell(Daughter) 2668 A. Gatehouse Dr., Baltimore, MD 21217 altimore, 20b. Place of Disposition (Name of Jeeneley, Company), or other place, H. And Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/05/10 Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Joseph H. Brown Jr. Funeral Home lleams 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as / consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Exami and burial-trar Due to (or as a consequence of) Box 68760, physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day signed by the ar 5 Other (specify) P.O. I □Yes 2 □No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No this certificate or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🗷 Natural death. 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) C 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Denne

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1104 JOYCE FAYE GRIMM Februar 10 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A

9. Birthplace (State or Foreign Country) Baltimore Good Samaritan Hospital 8. Date of Birth (Month, Day, Yea 1/17/1947 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days Hours Months 212-48-6766 63 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County the Marylan ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ XIo Director BALTIMORE MD PARKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21234 USA 1261 DEANWOOD ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1X Never Married 2 ☐ Married ò 1 □Yes 2 No Specify Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" d other than "natural" event, the Medical Ex Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ PARALEGEL LAW OFFICE 12TH GRADE of Health and Mental Hygie If item 27 is marked other to or other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be KENNETH W. GRIMM FANNIE GALLOWAY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. LOIS Y. HIVELY/SISTER 1247 DEANWOOD ROAD BALTIMORE. MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEM. PARK 2/17/2010 | HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO2 17 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myocord disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 █ No Month Dav 4 Pregnant at time of death 5 Other (specify) this certificate has been signed by the al director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 mellini 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Triknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ★ R/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sicia 400 53540 february 10,2010

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

00

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 20/6 M /Medical 4a. Facility Name (If not institution, give street and number) Nown, or Location of Death 4c. County of Death Examiner fo inder 24 Hrs. e 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 214-64-8762 1 № M 2 🗆 F 54 Yrs. Director Mary Usual Residence of Decedent 10b. Coun 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Experiment must be notified at 1 Yes 2 No Director Md MUTL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 M Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working if p. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) stodian enta Hea 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be file out of Health and Mental H Be roodman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 office Cousin boodman Injury or other altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ___ Department o Important: If any Injury or 21. Sign; ure f Funeral Service Livensee Lellos 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each Approximate Interval Betweer Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician everal disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) burial-t Box 68760. physician The law requires that the death certificate be Physician/Medical the been signed by the attending I should be detached for use as as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1 □ Yes 2 🗓 Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) v. Betreden Ave. Bat State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Janet Coleman Gillespie 8156AM -ch Ruar ZOIO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hedical Center Baltimore Washington Glen BURNIC ANNE ARUNDE . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginis **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min, (Month, Day, 08-13-1 Director 215-40-6063 Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🖾 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Baylor Road 21061 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married にろり1ピーランプル e, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Coleman Hattie Lorraine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Julie Weldon / Daughter 200 Juneberry Way Unit 1B Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Old Forge Cemetery 02-22-2010 Old Forge, PA 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MAONIC OBSMUCTIVE CUNG DISTASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner UNGUMON, A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work nours after death.

neral Director: Aft
filled in by the fur 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and fitle of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Aromoni SMINGTOR 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan			f Health a	and Mer	ntal Hygier	21111	03646
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Ed Ward	ace		4b. City, Tow	m, or Location o	Fe		Day Year 5 2010	
	Funeral Director		5. Social Security Number 6. Sex	ina Renabil	itation (ast birthday) Yrs.	If Under 1 Y	rofte	24 Hrs. 8.	Date of Birth (Month, Day, Yea -13-1921	ANNC ,	AYUNGCI holace (State or Foreign buntry) ryland
	ס	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aruno	10c. City	Oc. City, Town or Location Crofton						10d. Inside City Limits
	with the 34 or 28a	I Direc	10e. Street and Number 1736 Woodbridge Co	ourt		10f. Zip Cod	21114		10g. (Citizen of What Co	•
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (of Hispanic Orig Cuban, Mexican	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, Whit	nican Indian,
21215-0036	d within 72 ho giene. er then "natur . Ihe Medical	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	DO NOT use re	one during most		16b.	Kind of Business	
Maryland	should be filed ind Mental Hygid i marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Earl Eugene Grace	, Sr.				rs Name <i>(Fi</i> rah Ch	rst, Middle, Maide ilds	en Sumame)	
	and 2 sho balth and I n 27 is me		19a. Informant's Name/Relationship (Ty) Eleanor L. Grace							or Town, State, 2 Maryland	
Baltimore,	permit. Pages t a Department of He Important: If Item eny injury or oth once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State At 1	emetery, crer antic	sition (Name o natory or other Cremat	ory 0		010 G1e		e, Maryland
Ba	Depa Impo eny ir		21. Signatur of Funeral Service/Linear	s- chaven	M	1P., In	c., 725	0 Wash	. Blvd.,		ral Home at e, MD 21075
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	cations that caused the dear le cause on each line. AIZMIN Due to (or as a consequence)	crs .	DISTAL DISTAL		cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
1,092	te be executed ysicien and ie burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d.							
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregna Other (specify				23d. Date of delivery Month Day Year			
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	e given in Part I.			. /	the cause of death?
Division of Vital Records,	n: The law re ficate has be ir, page 2 sho	Completed							24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
of Vit	hysicia his certi il directo	To Be	TLI Yes ZIANO		ER/Outpatien		Other: 4 Nu		5 ☐ Residence	6 □Other (Spe	cify)
sion o	Attending Physician: or death. ector: After this certification in the funeral director.	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 Tyes 2 1		Describe how in	jury occurred	
Divis		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St						ural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	elician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the restigation, in r	ne time, date and my opinion, deat	d place, and th occurred a	due to the cause t the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier				ense number			Date signed (Mont	
	(A)		20 Name and address of	owen and	75C	R	1462	51	Hel	bruary	5,2010
	Sta	ıte	30. Name and address of person who co	mpleted cause of death (Item 0.95 32. Registrar's Signal	shult	e Dri	VĊ	EIKri	dge,	Maryla	5,2010 Ind 21075
	Registr		FEB 16 2010	1 A	hade	þ					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene U 1 U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FER 7:03 PM BEULAH M. GREENE 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours Min 1 🗆 M 2 🕱 F JUNE 28, 1945 Country) Director 212-46-2502 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No BALTIMORE PARKVILLE MD 10f. Zip Code 10g. Citizen of What Country? Funeral 7305 OLD HARFORD RD. 21234 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc à 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced BLACK Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) MAINTENANCE TOWSON STATE UNIVERSITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 0 JAMES OLIVER MINNIE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health an.
Important: If item 27 is any injury or other trau. MINNIE CARTER/MOTHER 7305 OLD HARFORD RD. BALTIMORE, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 TCremation 3 Removal from State BALTO. CREMATION CNTR 2-19-10 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ Acute Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury cardiovascular diseace Atherosclerotic that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown the þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires End stage renal disease, dyslipidemia Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown secondary hyperparathyroidism, chronic anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Natural work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Funeral D completed filled in Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) M.D. RESOOO FEB 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15601 LOCH RAVEN BLUD BALTIMORE MD 21239 MANDINI YADAV 31. Date filed 2. Registrar's Sigi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State Registrar				Cer	tificate of	Death		Reg. N	10.ZUIU	030	40
	Physicia	an/	Decedent's Name (i		,					2. Date of Month		Day Year	3. Time of D	
- 50	Medi	cal	JOHN WILLIA 4a Facility Name (if no					4b. City, Town,	or Location of I	Month FEB.		10 4c. County of Death	0421	М
	Examir	ier	4a. Facility Name (if not institution, give street and number) _ANNE_ARUNDEL_MEDICAL_CENTER					ANNAP		Death	4	ANNE ARI	INDFI	
Π	Funeral		5. Social Security Num	nber 6. S	ex 7. Ag	je (In yrs. last	birthday)	If Under 1 Yea Months Days	r If Under 24		Birth Day, Year)	9. Birth	place (State or I	Foreign
	Director		230.10.6807 Usual Residence of De		XXM 2 D F	90	Yrs.	Wichthio	Tiours		28, 19		OKE, VA	
	and show	ō		0b. County		10c. City, 7	Town or Loc	cation				1	od. Inside City	Limits
	Maryla 18a-f	Director	MD	ANNE AF	RUNDEL		SEVER	NA PARK					1 ☐ Yes 2	ON XXS
	a or 2		10e. Street and Numb	er				10f. Zip Code			10g. C	Citizen of What Cour	itry?	
	th with ms 23 must	Funeral	364 DUNROBB	IN DR.	T				21146		<u></u>	USA		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٥	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Decedent Armed Forces? 1 Ves 2 If Yes, Give Year or Dates.		l I	Vas Decedent of Yes, specify Cul ☐ Yes 2 √ X N	oan, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: WH		
Maryland 21215-0036	hin 72 hour ne. than "natu ie Medical	Completed		15. Decedent's E iy only highest gr day (0-12)			(Give I life. Di	lent's Usual Occu kind of work done O NOT use retired	during most o	f working	16b.	Kind of Business Inc	dustry	
i D	ad wit Hygie other ant, th	Bec	12 17. Father's Name (Fire	st Middle Last)	4+		AT	TORNEY	18 Mother's	s Name (First, Midd	lle Maide	LAW FIRM		
<u>a</u> ŭ	be file lental rked c	욘	JAMES WILL		TON GOFF				1	A TRACY WOL		ii Surname)		
ary	12 should that and Metalth and Metalthand Metalthand Z7 is marker traumatic		19a. Informant's Nam	e/Relationship (7	ype, Print)		19b. Mailin	g Address (Stree	t and Number o	or Rural Route Num	ber, City	or Town, State, Zip (Code)	
Σ	nd 2 s ealth m 27		GEOFF G. GO		SON				SEVERNA I	PARK, MD 21	146			
Baltimore,	ge 1 a nt of H : If ite		20a. Method of Dispos 1 🖾 🛣 Burial 2 🗀	Cremation 3X	Removal from State	cem	netery, cren	sition (Name of natory or other pl	ace)	Date	20c.	Location - City or To	wn, State	
<u>=</u>	artmer artmer ortant injury		4 Donation 5			PROVI		JNITED MET	H. Fl	EB. 12, 201	9/ <i>L</i>	irgin	LE	
Ba	permi Depar Impoi any ir once.	6 3	21. Signa n. f Fjuner	GREGORY	FINK	MOT148		- NNK TUNER 126 CRAIN		P.A. GLEN BURNI	E. MD	21061		
المراسب الم	nysician/ Medical Examiner		23a. Part I Enter the shock, or heart f Immediate Cabse (Fir disease or condition resulting in death)	allure. Listionly	plications that equse one cause each lin a. Due to (or as	e. EVW	M	r the mode of dy	ing, such as ca	rdiac or respiratory	arrest,	1	Approximate Interval Betwee Onset and Be	e e n ,
8760	icate be executed physician and s the burial-transit	Medical Examiner	Sequentially list cond in any, leading to imm cause. Enter Underlyi Cause (Disease or linj that initiated events resulting in death) Las	ediate ng jury	b. Due to (or as c. Due to (or as d.									
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal d	eath 3 🗆	Ectopic pregnal Other (specify)	ncy		-	23d. Date of delive	ery Day Yea	ar
ds, P.O	quires that the series of the signed by the details and be detailed.	ed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1								~/ -	ne cause of dea		
Division of Vital Records,	Physician : The law rec r this certificate has bee ral director, page 2 sho	Completed by Physician								24a. Wa au pe 1 🗆 Ye	topsy rformed?	death?	psy findings ava mpletion of cau 2 No	ailable use of
ita	ician: certific rector,	Be	25. Was case referred examiner?	1.1	Hospital:			_ Tot	Place of Death	(Check only one)				
<u></u>	Phys	<u>ان</u>	1 Yes 2 27. Manner of Death	70	28a. Date of inju	ient 2 🗆 EP	R/Outpatien Bb. Time of	t 3 □ DOA 00 28c. Inju	4 ∐ Nurs	ing Home 5 Re		6 Other (Specify,	1	
u C	nding ath. r: Afte e fune	icat	1 Natural 2 Accident	5 ☐ Pending Investigation	(Month, Da	y, Year)	injury	wo	rk? ∐Yes 2 □ N	1	21.011 mg	ary occurred		
Division	tal or Attending Phys rs after death. al Director: After this ed in by the funeral di	al Certificate:	3 ☐ Suicide (4 ☐ Homicide	6 Could not be determined	28e. Place of Injuding, et	ury - At home c. (Specify)	e, farm, stre	et, factory, office			(Street a own, Stat	and Number or Rural te)	Route Number,	Ş
	Hospi 24 hou Funer rted fill	Medical	29a. Certifier 1 (Check 2	Medical Exam	sician: To the best of iner: On the basis of e	examination ar	nd/or invest	igation, in my opir	ion, death occu	rred at the time, date	e and plac	ce, and due to the cau	use(s) and mann	ner stated
	o the orther orther orther orther	Ž		Certifying Nur e of certifia	Practioner: To the	best of my kr	nowledge, d	eath occurred at 1		nd place, and due to		e(s) and manner as sta Date≱sign≱d (Month, L		
	- \$ - 0		2/04	enlor	ele U	1		1	1638	54	2	2/1/10		
1	DV		30 Name and address	of person who	completed cause of d	eath (tem 23	a) (Type, P	Rition	202	20 RM	Am	DIROAN	UMi	4()

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 Day Physician/ Leonard Leroy Garrish, Jr. Feb. 2010 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5600 Sweet Air Rd. Baldwin Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 F Months Days Hours Min. April 8, 1 **Director** 84 220-14-0865 Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Directo 1 ☐ Yes 2x ☐ No MD Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5600 Sweet Air Rd. 21013 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 √ No Specify: '45-'46 Specify: **3** Widowed 4 □ Divorced white Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 8 n/a Carpenter Construction other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Leroy Garrish Mary Madeline Leaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Wayne Garrish/Son 5600 Sweet Air Rd., Baldwin, MD 21013 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Gardens 2/15/10 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility

Lemmon Funeral Home of Dular
10 W. Padonia Rd. Timonium

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, emmon Funeral Home of Dulaney Valley, Inc. O. W. Padonia Rd., Timonium, MD 21093 Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to or as a consiquence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown as been signed by the 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ischemic Cardiomyopathy this certificate has autopsy page 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 🔀 No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 K Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; After the function of the functin 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 To the F only or Certifying plurge Practioner: To the best of pry-knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number Elmary 12, 2010 D22645

3+1

Registrar
DHMH 17 Rev 7/2009

7505 Osler Dr., Suite 308 Towson, MD 21204

and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Fredric Sirkis,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene "Inportant: If item 271s marked other than "natural", or items 23a or 28a-f show a my injury or other traumatic event, the "Noticel Eseminar ment on Defined at once." 1 ☐Yes 2 No Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ≥ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၟႄ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) регтит. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hand illure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 1 Yes 2 No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) P.0. ed by the a 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes COLITI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ∐ Yes of Vital After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Tyes 2 □ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) M3, FAC 2010 -5155 DNLOLOGIST HEMATOLOGIST

State Registrar SEIN

AUNG,

31. Date filed (Month, Day, Year)

DRIVE

BALTIMORE, MD 2123

9000 FRANKLIN SQUARE

22 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9:30 a.m. FEBRUARY 13, 2010

STANLEY GULCZYNSKI

			Plea	ase Type or F								•	.
	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1								0.000				
		1. Decedent's Name		. ,				OIL	Catil	2. Date of D			3. Time of Death
Physicia Medic	al				s Gulczynski				Februar Februar				
Examin	4a. Facility Name (if not institution, give street and number) Stella Maris Hospice 4b. City, Town, Timonia						miu	Location of Deat	1	40	Baltimor		
Funeral Director		5. Social Security No. 1 33–16–5 1	11	6. Sex 1 X M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month, D	irth a <i>y, Year)</i> 4, 19	C	irthplace (State or Foreign country) W York
and show	tor	Usual Residence of 10a. State	10b. County			ty, Town or Lo							10d. Inside City Limits
e Maryl 28a-f notifie	Jirec	MD		timore]	Baltin ——							1 🗌 Yes 2 🔀 No
s 23a or	Funeral Director	10e. Street and Nun 2 628 Jopp		race			10f. Zip (2123	4		10g. Ci	U.S.A.	Country?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien az is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marri 3 Widowed		If Von Cive	es? X No	- 1	Was Decede f Yes, specif 1 Yes 2		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Am Black, Wh Specify: W	ite, etc.
15-C	Completed		cify only highe	nt's Education est grade completed)		(Give	dent's Usual kind of work O NOT use r	done di	ation uring most of wo	king	1	Kind of Busines	
212 within giene. er thar		Elementary/Second 12	onday (0-12)	College (1-4	or 5+)	Fi	refig	ghte	er		Ba	ltimore (lity
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth	To Be	17. Father's Name (I Edward G	ulczy	nski					18. Mother's Nar	ne (First, Middle a Kozlow		Surname)	
Mar 12 shoutth and 27 is n		19a. Informant's Na Geneviev		hip (Type, Print) CZYNSKi/	Wife	1	-		nd Number or Ru Terrac				
Baltimore, permit. Page 1 and Department of Hee mportant; If item any injury or othe ance.		20a. Method of Disp	oosition	3 Removal from St	20b. I	Place of Dispo cemetery, cren Star Cemet	sition (Name	e of	1	Date 2 0/ 2010	20c. L	ocation - City o	or Town, State
Baltin permit. F Departm Importa any inju		21. Signature of Fur			1)	Cemet E	P. Name and Vans	Addres Fur	s of Facility neral Cl Ford Roa	napel & (<u> </u>		
		shock, or hear	t failure. List o	complications that cau	ised the deat							, 15 412	Approximate Interval Between
Medical		di e se or conditio res ting in death)	Final n		IC OBS		VE PUI	LMON	ARY DISI	EASE			Onset and Death
Examiner	L	Sequentially list con	with we	bue to (or	45 4 5511654	uonos on.							
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Box 68 death certifi he attending	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 2 Unknown 2							у			23d. Date of d Month	elivery Day Year
S, P.O. BK res that the des signed by the a		Part II. Other signif	icant condition	ons contributing to dea	th but not res	sulting in the u	nderlying ca	ause give	en in Part I,				to the cause of death?
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Rec The la										perf 1 🗆 Yes	ormed? 2 X N	death?	es 2 🗆 No
of Vital Re Physician: The this certificate ral director, pag	To Be	25. Was case referred examiner? 1 ☐ Yes 2 🗶	No Medical	Hospital:	natient 2	ER/Outpatier	nt 3 🗆 DO4	Othe	r:		idence 6	Other (Spe	ecify) HOSPICE
로 즐근 중 글	Certificate: T	27. Manner of Death 1 X Natural 2 Accident	5 Pendir	28a. Date of (Month, gation		28b. Time of injury		c. Injury work?	at	28d. Describe			ON HOSPICE
Division o Hospital or Attending 24 hours after death. Funeral Director: After		3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inod 28e. Place of	Injury - At ho , etc. (Specify	ome, farm, stre	eet, factory,	office		28f. Location City or To			ural Route Number,
Division To the Hospital or Attention within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2	Medical E	Physician: To the best Examiner: On the basis Nurse Practioner: To	of examinatio	n and/or invest	tigation, in m	y opinior	n, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
To the vithin 2 to the comple	_	29b. Signature and	title of certifier	Allni L	CA	P	29c. i	License	number		29d. Da	te signed (Mon	
		30. Name and addre	ess of person	who completed chause of	of death (Iten	n 23a) (Type, P	Print)	n/<	1 JUXY		0	X//J/0	2010
Stat	e	JENNIFE 31. Date filed (Mont)				ANEY V		RD.	TIMONI	UM, MD	2109	3	
Registra	ır	31. Date filed (Month	1763	110 Sener	J.	par	-			·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Loch Raven VA Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2 F Months Days Hours Min. 220-01-0971 90 Director Baltimore, Maryland January 26, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examirer must be notified at Director Maryland Baltimore Cockeysville 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Gitizen of What States 21030 413 Lake Vista Circle H death v of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 white 1 ☐ Yes ZYNo Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12 should be filed with and Mental Hygier 7 is marked other th Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry J. Grund Marie A. Koehnlein ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Mrs. Evelyn M. Grund/ wife 413 Lake Vista Circle H Cockeysville, Maryland other t Department of Healt Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 9, 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 Donation 5 Dother (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MCE disease or condition resulting in death) Luna Ca /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? Yes 200 No certificate 1 □ Yes 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this (1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 2 Accident neral Director: / 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) D23767 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LochRaven Blo DEBRA HEIMERTO

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A HAR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ln Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age Un yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours Min. Usual Residence of Decedent Director 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10é. Street and Number Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DQ NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) RIVIER YR9 FETTORA, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. 19R099 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21/17 ALACE COUR MARLENE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation) 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility me 23a. Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a cónse uence of Examiner Due to The law requires that the death certificate be executed and Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen (24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an Was a... autopsy performed? Vas 20 No within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 20 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1-Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 1:00 A M February 2010 SAMUEL GOLDBERG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. KESWICK MULTICARE N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Director 219-28-4011 76 10/22/1933 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 💢 No notified Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 13 POMONA SOUTH, or items 23a 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SALES MEN'S CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ABRAHAM **GOLDBERG** ပ DORA SIEGEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 POMONA SOUTH, #7, PIKESVILLE, MD 21208 Disposition (Name of Date 20c. Location - City or Town, S PATRICIA GOLDBERG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 02/09/2010 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 weeks bran alscer Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cardianus a 2 No 3 Probably 4 Unknown 1 🗌 Yes Leavet trausplan 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number Danbelly Tax February 7,2010 Gregor PZD 913657

State Registrar N 18 ABELLE 31. Date filed (Month, Da

DHMH 17 Rev 1/2001

THERRETOR, 700 W. 40 th STREBT, BALTIDARE, MD21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

Dennis Michael		gory Ś 1- For State	tate of Maryla	and / Depa		f Health and			Reg. No.	201	0 0365
Physici Medical Exam	an/	Registrar 1. Decedent's Name (First, Midd	, ,	·				2. Date of [Month		Year	3. Time of Death 1940 hrs
ijigaleai Exam	illei	DENNIS MICHA 4a. Facility Name (if not institution Sinai Hospital				4b. City, Town, or Baltimore	Location of De			County of De	
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year		_	Birth (MM/D	D/YYYY) 9.	Birthplace (State or
Director	217-92-3045 1XM 2 F 41 Yrs.					^{din.} 10–	8-1968	} For	eign Country) <u>MARYLAND</u>		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion	_				10d. Inside City Limits
*	o	MD.	N/A	В.	ALTIMOR	ĽΕ					1 X Yes 2 No
ne Maryl or 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What C	ountry?
with the	ral D	3610 SEQUOTA 11. Marital Status		edent Ever in U.	S. 13. Wa	21215 s Decedent of His		Specify Yes or		JSA 4. Race - Am	erican Indian, Black,
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be potified at once.	Funeral		farried Armed Fo	2 X No	lf Y	es, specify Cuban	, Mexican, Pue	rto Rican, etc.)		White, etc	
rs after ural",	ত্র	3 Widowed 4 Dir 15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates:			Yes 2 No		of work done		nd of Busines	LACK
5 72 hou n "nat al Exa	eted	Elementary/Secondary (0-12)				ost of working life.			105. 1	id of busines	so in dustry
within giene.	Completed	-12- 17. Father's Name (First, Middle	-0-	. 1	LAB	ORER	10 Mothor's No	me (First, Midd		O DET	AIL
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	MICHAEL GREG						AINE JO		urrame)	
→ 본 점 : □ □	리	19a. Informant's Name/Relations	ship (Type, Print)			Address (Stree	t and Number o			or Town, Sta	ate, Zip Code)
e, MD I and 2 sho Health and item 27 is		PRISCILLA JO: 20a. Method of Disposition		20b. F	Place of Dispos	SEQUOIA ition (Name of cen		BALTIMO Date			D 21215 or Town, State
Baltimore, permit. Pages I and Department of Heal Important: If iter injury or other tra		1 Donation 5 Other S	n 3 Removal fro	Mich	crematory or oth			16 201	O DATT	ידאַ סער	MARYLAND
Saltil ermit. Pepartm mports njury o	Ì	21. Signature of Funeral Service	Cicensed ONATH	AN D. H	IBNER ^{22. N}	lame and Address	of FacilityPH	ILLIPS	FUNERA	L HOMI	E, P.A.
Physician	-	23a. Part I. Enter the disease, or	V.41	Brei	√ 172	1-27 N.	MONROE	ST. BA	LTIMOR	RE. MAI	RYLAND 21217 Approximate Interval
Medital Examiner	2	fature. List only one cause	on each line.			, ,					Between Onset and Death
LAGIIINGI		or condition resulting in death)		consequence of) :						
	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence of	7):						
ted 	Examiner	(Disease or injury triat initiated events resulting in death) Last	Due to (or as a	consequence of):					-	<u>-9</u>
e executed cian and rial - transit	Physician/Medical	UNPENDED	d AMENDED	<u>.</u>							1
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the burn	n/Me	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregr		al death 3	Ectopic preg	inancy	- 1	Date of deliv	ery Day Year
ox 687 eath certific attending I	sicia	past 12 months? 1 Yes 2 No 9 Uni	4 Pregna	ant at time of dea	ath =	ner (Specify)			"	101101	Day Tour
D.O. Be that the de ned by the detached fi		Part II. Other significant condit	9 Unkno		sulting in the u	nderlying cause g	iven in Part I.	23e. Di	d tobacco us	se contribute	to the cause of death?
rds, P.(requires that been signed hould be detailed.	g p					_		1 🗆	Yes 2 🗸	No 3 Pr	obably 4 Unknown
cords, law require has been so 2 should	Completed								topsy	prior to	autopsy findings available o completion of cause of
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of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should b	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hospital:	npatient 2	ER/Outpatient		of Death (Chec	sing Home 5	Residence	ce 6 Oth	ner:
n of ding Ph. After t	Ηl	27. Manner of Death	28a. Date (Month)	of Injury Day,Year)	28b. Time of Ir		y at Work?	28d. Descril Subject s	ne how injury	occurred	
Division tal or Attendi rs after death.	catic	2 Accident Inve	stigation			-,	es 2 V No			Mumber or I	Dural Pouta Number City
Control of the contro							28f. Location (Street and Number or Rural Route Number, City or Town, State) 3722 Oakmont Avenue, Baltimore, MD				
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To with	Mec	29b. Signature and title of certific	and manner st	ated.		29c. License	number		29d. Da	te signed (N	fonth, Day, Year)
		0-10-	- ,wa			O.C.N	/ I.E.		Febru	ary 5, 20	10
31	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	200	31. Date filed (Month, Day, Year)	500	gistrar's Signatur	0	3-0					
Regist		FEB 16.2	2010 /2	us A.	MORA				_		
DHMH 17 Rev 1/2	J01	_			ORIGINAL	<u>_</u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#1&26perPHYS, G900, 2/16/2010, W5 State of Maryland / Department of Health and Mental Hygiene 3656 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) James F. Haag 1/29/20^{Day} **Physician** 8:25am™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Angels Touch Assisted Living West Friendship Howard If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

TX 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 054-01-1744 1**½** M 2 □ F 91 Director Usual Residence of Decedent 10d, Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County Massapequa Park NY Nassau 1XX es 2 No Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 23a or ust be r with 11762 USA 32 Third Ave an "natural", or items 23s Medical Examiner must death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or ite 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 If Yes, Give Year or Dates: 41–48 1 Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Telephone Engineer the s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic events. Fred M. Haag Ida Mitchell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4725 Orchard Street, Orient NY 11957 James F. Haaq Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Calverton National 2/3/2010 Calverton, NY 4 ☐ Donation 5 ☐ Other (Specify) Doda ²² Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 21. Sign sture of Funcial Service Licensee Victor any Ir 1) C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
UN KNOWN Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) ZWKS Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran and Due to (or as a consequence of) Box 68760, physician certificate be Physician/Medical the attending IF FEMALE: - use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ✓ ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? Yes 2 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Other: 4 Nursing Home 5 Nother (Specification Home Hospital: 1 Yes 27 No 2 ER/Outpatient 3 DOA မ 1 Inpatient this funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: the Hospital or Attending I bin 24 hours after death. the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title completed cause of death (Item 23a) Type, Print)

+ MANNON TOS Dickital 30. Name and address of person Steg, Linthicam, MDZ1090 (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Madelvn Ella Hawkes February 2010 9:00 P 11, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10845 Gambrill Park Rd. Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 78 558-42-8716 Director March 18,1931 Maine Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10845 Gambrill Park Rd. 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nn any Injury or other traumatic event, the Media once. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace William Townsend Eunice Rockwell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James G. Hawkes / Husband 10845 Gambrill Park Rd., Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/13/2010 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service M00382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Stiple Loline 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Weeks disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Multiple Sclerosis 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami P.O. Box 68760 sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Breast Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home TResidence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Direc 4 Homicide Certifying P ... cian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 yedical Exa in :: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title rtifier 29c. License number 2/12/2010 D31912

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Julio Menocal M.D.; 110 Baughmans Lane, #140, Frederick, MD 32. Pegistrar's Signature Queva

30. Name and address of Person who completed cause of death (Item 23a) (Type, Print)

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G900 2/18/2010 Ih State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gladys G. Day 2010 Year Huamani Feb. 8:20 PM 6. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12712 Hathaway Dr. Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 212–55–4639 (Unknown) Date or L. (Month, Day, 22 **Funeral** 1 M 2 TF Months Days Hours Country, Peru 66 Director Sept. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12712 Hathaway Dr. 20906 Peru "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Peruvian If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0swaldo Valcarce1 Benedicta Silva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juan E. Huamani / Husband 12712 Hathaway Dr., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/12/2010 Beltsville, MD ²². Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 2 Signature of Funeral Service Lice M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Circlesis Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: ၉ 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred 5 Pendina 1 Yes 2 No _`Accident Investigation Suicide 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number

DHMH 17 Rev 7/2009

State Registrar 1706 Fallsm

881800

Gr. Grazvann

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 10,2010° **Physician** 9:09 P Rainer 0. Herrscher /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1/97t2/31/938 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 118-32-6148 1 XM 2 □ F 72 Germany Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 282.6 cm. any injury or other traumatic event, the Menteur E. 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 No Director NY Nassau Farmingdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 35 Frank Avenue 11735 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married White 1 □Yes Z No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 🂢 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) Hildegard Johann Herrscher ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35 Frank Avenue, Farmingdale, NY 11735 Roger W. Herrscher 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pinelawn Memorial Park 2/17/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pinelawn, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Arthur F. White F.H., Inc. 21. Signature of Fu erai Service Licensee T. Harman 15 Conklin Street, Farmingdale, NY 11735 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Verticula Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ongestive The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day ρ 5 Other (specify) 1 ☐Yes 2 ☐ No page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐Yes 2 No 2 No 1 ☐ Yes or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital c within 24 hours at To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V Laurel Regional Hospital, 7300 Van Dusen Road, Laurel, MD Mohamed Tourky, MD 31. Date filed (Month, Day, Year) **FEB 16 2010** 32. Registrar's Signature State pare Registrar

DHMH 17 Rev 1/2001

10-00821 Audry Holmes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 03660 State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Amend#1 per Me G901 3/31/10 Pertificate of Death 1. Decedent's Name (First, Middle,Last) Audrey Lee Veney 2. Date of Death 3. Time of Death Physician/ Month Day January 28, 2010 Medical Examiner 2135 hrs Audrey Lee Holmes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5418 Forest Road **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 220-64-0838 Months Davs Hours Director 6-16-1955 1 M 2X XF 54 Country) MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No s 23a or 28a-f shove notified at once. 28a-f shor Baltimore na Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1933 St Paul Street 21218 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2X No 3 Widowed 1 Yes 2X No specify. 4 Divorced If Yes, Give Year Specify: Black 2 16a. Decedent's Usual Occupation (Give kind of work done timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hours travent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tem 27 is marked other than ' traumatic event, <u>the Medical</u> 11th grade na Sales Clerk Hecht Co. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Arthur Gamble Ruth Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Ruth Wilson-Mother 5418 Force Road Balto, <u> 21206</u> 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, Loudon HPark 3-1-10 1 Burial 2 Cremation 3 Removal from State Baltimore Carrison Forest 11-10 Owings 4 Donation 5 Other Specia 21. Signature o F neral S i i icens March East F/H 22. Name and Address of Facility 1101 E. North Avenue MD 21202 111 **Physician** 23a. Part I. Exper the disease, or con, lice tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease Methadone and alcohol intoxication and narcotic use xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and per me,20b,c per fh g901 3-29-10 vt a,27,28a-f,perME G900 2/18/10 TT Physician/Medical AMENDED 23a X UNPENDED attending physician for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown signed by the a Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? this certificate page ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other Scene 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural Director: d in by the f 5 Pending 1 Yes 2 X No Fd 9:00 pm Fd 1/28/10 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5418 Forest Rd Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide rann 24 hours.
To the Funeral D.
completely filt determined (Specify) found in dwelling Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29b. Signature and offe of certifie 29c. License number 29d. Date signed (Month, Day, Year) 300 January 29, 2010 OCME ·U Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month Day Year) 6 State Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ NA 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Med.Center Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 212-42-0213 Months Hours 1 □ M 2 🛛 F Maryland Director 67 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healith and Mental Hygiene. Important: If tiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Glen Burnie MD Anne Arundal 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7885 Gordon Court 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Head Start 10th Grade Dietition Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Viola Dorsey Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 470 Cornell Ct.,Glen Burnie,MD 21061 Diane Thomas (neice) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Church_Cem. 02/13/10 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Halls Signature of Funeral Service Licensee ²² Name and Address of Facility Own Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARTERY DISEASE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of,: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year the detached g 🗌 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar ad title of certifier

30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

29b. Signature

29c. License number

D0056046

29d. Date signed (Month, Day, Year)

Suite 203, Glen Burnie, M.D. 2106/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) . Birthplace (State or Foreign Country) Age (Iri yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 217-56-814 1 M 2 W 63 irginia **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show must be notified at 1 Nes 2 No Director altimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21213 USA 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. or items 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 ☐ Married 1 Yes 2 If Yes, Give Year or Dates 2 No Specify: Baltimore Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working ife. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Manager 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ıtal marked urrie ar ပ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21206 item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any injury or ot Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral 22. Name and Address of Facility owell Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Due to (or an construence of): **Physician** /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): d by the attending physician detached for use as the buris Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de þ 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 Tes 2 🗌 No Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 4 \sum Nursing Home Hospital 2 X No 3 DOA 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient ၉ filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury 28b. Time of 27. Manner of Dath Certification: (Month, Day Year) Injury Pending investigation 1 Natural 1 🗌 Yes 2 No death. é ☐ Accident after deat 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 6 within 24 hours a

To the Funeral D the Hospital 29a. Certifier Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature d title of certifier RES- 220 CH. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Bran M. Thomas

31. Date filed (Month, Day, Year)

FEB 16 2010

Summer

32. Repistrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mars February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 215-54-0585 16,1949 March Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Xes 2 No Director tomore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö 21205 items 23a Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Medical If item 27 is marked other or other traumatic event, Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) Be tarrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 reorge altimou 20a. Method of Disposition
1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot Pathmore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I censee 22. Name and Address of Facility MD ZIZI 3 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** nonic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.) Examiner war 8100 or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Year 4 Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 4 1 Tyes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examine 1 Yes Hospital: Other: 4 \square Nursing Home 5 \square Residence 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ည To the Funeral Director: After this completely filled in by the funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: injury 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 MWATHA KENNE TH

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32.

Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 2/15/2010 1:30 PM Jeanette Marie Hawk /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Brinton Woods Nursing & Rehab Center Sykesville Carroll If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months Days Hours 1□ M 2 1 F 3/15/1931 Director 382-28-3426 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or items 23s or 28s-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location item 27 is marked other than "naturel", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Carroll Finksburg 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code USA 2174 Old Mineral Hill Rd. 21048 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronic Assembler General Dynamics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be ပ Clarence Ernest Mary Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Depertment of Health a important: if Item 27 is eny injury or other trains 2174 Old Mineral Hill Rd., Finksburg, MD 21048 Ernest Hawk/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 2/16/2010 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory Winfield, MD 21. Signature Funeral Service Ligensee Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 or the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lear failure. List only one cause or each line. **Physician** ARTORIUS CLORETIC CARDIOVASCULAR DIS OASC Immed te C use (Final disease or addition resulting in seath) /Medical Examiner Physician/Medical Examiner attending physician and for use es the bunal-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown SAWAL STEWOSIS Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1868174 has 1 Yes 2 TNo 1 Yes 2 TNo 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as steted. Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only 29d. Date sigped (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License number 20806 2010 Musey 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 1000 Liberty Rd., Eldersburg, MD 21784

TURNES

and

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore Washington Med Ctr</u> <u>Glen</u> Burnie Arundel Anne 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Hours Min. 01/1 Day, Country) Director 214-22-5186 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 226 Atlanta Road U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 MNo Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. 1 other than "u Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked of <u>Stanislaus Bogoslawski</u> Bertha Lillian Bogoslawska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Homer J. Hunter / Husband 226 Atlanta Road, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cem 02/09/10 Baltimore. 21. Signature of Faneral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, Riviera Drive, Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Exami Cause (Disease or iinjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical law requires that the death certificate be Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death the detached 9 Unknown 9 Unknown signed by t Id be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 autopsy Hospital or Attending Physician; The 2 🗆 No Yes 1 Yes rector, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 Celtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 50. Name and addre 101 Drae 31. Date filed (Month, Day, Year) State Registrar FEB 16 2010

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			Registrar 1. Decedent's Name (First, Middle, L	3. Time of Death						
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	Funeral			Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign
	Director		215-14-0998	1 □ M 2 X F 89	Yrs.	Months Days	Hours Will.	(Month, Day, July 24	1920	Maryland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	laryla 3a-f s ified	Director	Maryland Baltim	ore	Catons	ville				1 ☐ Yes 2 🛣 No
	or 28		10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	s 23a ust b	Funeral	2230 Old Frederi	ck Road		2	1228	1	USA	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ∏ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, c, White, etc. White
2-0	2 hour	plet	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup kind of work done o	ation Juring most of work	ina	16b. Kind of Bus	siness Industry
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ary	hould and M s mai		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailii	ng Address (Street a	and Number or Rura	al Route Number,	City or Town, St	ate, Zip Code)
Σ	nd 2 sealth an 27 i		Jeffrey Hutchin	s/Son	6254	Hidden C	learing,	Columbia	Marylar	nd,21045
ore	e 1 ar		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	□ Romoval from State	b. Place of Dispo cemetery, crer	natory or other plac	e)			City or Town, State
<u> </u>	t. Pag tment tant: ijury o		4 Donation 5 Other (Spe	ecify)		dge Memor				e, Maryland
Ba	permit Depar Impor any ir	1	21. Signature of Funeral Service Lice	Muy						neral Home,Inc. aryland,21075
П			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl							Approximate Interval Between
	hysician/	H	Immediate Cause (Final disease or condition	Al	Lzheimer	s Disease				Onset and Death 5 Years
	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con:	sequence of):					
	d d ansit	Examiner	cause. Enter Underlying Cause Disease or injury that initiated events							
	ate be executed ohysician and the burial-transit	EX	resulting in death) Last	Due to (or as a cons	sequence of):					
00	tte be hysici he bu	dical		d						
687	artifica ling p e as t	/Me	IF FEMALE:	23c. If yes, outcome of pre	onancy					
×	eath certifica attending ph d for use as th	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mon	e of delivery hth Day Year
P.O. Box	requires that the de been signed by the should be detached	hysi	1 Yes 2 VNo 9 Unknown X	9 Unknown		- + (-,,)				
P.0	that t ned b e deta	y P	Part II. Other significant conditions	contributing to death but no	t resulting in the u	underlying cause giv	en in Part I.	23e. Did tob	oacco use contril	bute to the cause of death?
ds,	quires en sig ruld b	ted I						1 □ Y	es No	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	law rec has ber je 2 sho	plet						24a. Was a	sv pi	Vere autopsy findings available rior to completion of cause of
Re	The Late h	Con						1 Yes		eath?
ta	ician; certifii ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Pla	ace of Death (Chec			Ass 15ted
\	Phys this ral dir	10	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	2 ER/Outpaties 28b. Time of	nt 3 🗆 DOA	4 ∐ Nursing Ho	ome 5 Reside		
o u	nding tth. : After e fune	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, Day, Yea		work		Zod. Decombe no	w mjary obbano.	,
isic	or Attendi after death Director: A in by the fi	Certificate:	3 Suicide 6 Could no	t be 28e. Place of Injury - A		eet, factory, office				r or Rural Route Number,
2	ital or urs aftural Dir ral Dir lled in			building, etc. (Spe	scriy)			City or Town	i, State)	
Due to (or as a consequence of): Causer (b)seases on injury transition of the control of the								to the cause(s) and manner stated.		
	To the To the Complex	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
0	1.21		P	W M	// <u>/</u>	D5	6531		2.12	2010
	40 N			o completed cause of death (item 23a) (Type, I	my # 36	1 Colu	MOIAN	nd 21	1045
	Stat Registra		31. Date filed (Month, Day, Year) FEB 16 2010	32. Registrar's Si	gnature	1	1			
	negistra	40	FD TO SOIL	perme s.	gares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chiem Но February 2010 12:40 P^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex 7, Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign China China 1**x x**M 2 □ F Days Months Hours April 10. Director 586-26-6858 Usual Residence of Decedent i Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD1 🗌 Yes 2 🛂 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16016 Mills Orchard Drive 20878 United States 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Asian 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner-Operator Restaurant Be permit. Page 1 and 2 should be filec Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transcript 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lai Ho Quynh Tu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Ivy Ho - Daughter 16016 Mills Orchard Drive, Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State |Meadowridge Mem. Pk. | 02-17-2010 | 4 Domation 5 Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service Licens e 22. Name and Address of Facility Gary L. Kaufman Funeral Tome at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 ₹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician, Ventricular Arrythmia Medical resulting in death) Due to (or as a consequence of): Examiner Acute Myocardic Infarction Sequentially list conditions, if any, reading to immediate Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit Coronary Artery Disease Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Gasterointestinal Bleeding Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 Yes 2 No 1 A Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral C Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0062435 02-04-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Eisayyad, MD, 10110 Molecular Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Jeremy Hollins			or Print in Black I				gible.	03668
Seletify Hollins		State 1- For State	te of Maryland / Dep <i>Ce</i>	ertificate of Dea			2010	03300
Physicia		Registrar 1. Decedent's Name (First, Middle,I		iii		2. Date of Deat	eg. No. h	3. Time of Death
Medical Exami						Month February 1	Day Year 12, 2010	0409 hrs
4a. Facility Name (if not institution, give street and			give street and number)	4b. City	, Town, or Location of De	ath	4c. County of Death	
		I 81 Northbound @ Exit			gerstown	lo pur (pir	Washington	(0)
Funeral Director		212 10 11-0	5d		nder 1 Year If Under 24h hths Days Hours M	fin. 8. Date of Birt	th(MM/DD/YYYY) 9. Bir	in 11/1
Director		UG3-68-7557 1 Usual Residence of Decedent	M 2 F 36	Yrs.		100	(8-1918 Co	untry) // 9
a ny		10a. State 10b. County	10c. Cit	ty, Town or Location	111			10d. Inside City Limits
<u>* . </u>	<u>~</u>	NY New	York	New 9	ork			1 Yes 2 No
Maryla 28a-f 1 at ou	Director	10e. Street and Number	th 11 1		Zip Code	10	og. Citizen of What Cour	ntry?
r death with the Maryland or items 23a or 28a-f show must be notified at once,		360 West 117	Street		10026		USA	
th wit cems 2	uneral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ever in Armed Forces?		dent of Hispanic Origin? (cify Cuban, Mexican, Pue		14. Race - Ameri White, etc.	can Indian, Black,
er dea	ш		1 Yes 2 No led If Yes, Give Year	1 Yes	2 No specify:		Specify: B	call
21215-0036 Montal Hygiene. marked other than "natural", cevent, the Medical Examiner.	d by	15. Decedent's Education (Specify	or Dates:	16a. Decedent's Usu	al Occupation (Give kind o		16b. Kind of Business/I	ndustry
5 72 ho na "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of v	vorking life. DO NOT use r سر	etired)	11 /	
5-0036 led within 7 Hygiene. other than	티	12	NIA	Mainta	nance En	gineer	Maintan	ance
15-C		17. Father's Name (First, Middle, La	[]. []		18. Mother's Na	ne (First, Middle, M	faiden Surname)	
2121 Muld be fil Mental H marked c event,	To Be	19a. Informant's Name/Relationship	/70////\S	19b. Mailing Addre	ss (Street and Number of	OG/G	ber, City or Town, State	. Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked offer than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	-	Barbara Ho	Mins	360 4	lest 117th	St NY	NY 100	26
e, realt		20a. Method of Disposition	20b	Place of Disposition (No		Date	20c. Location - City or	Town, State
MOFe, Pages 1 a nent of He ant: If ite		1 Burial 2 Cremation 4 Donation 5 Other Spec	Removal from State	Ixford His	1/5 2.	-20-2010	Chester 10	lew Tork
Baltil Permit. Departm Importa		21. Signature of Puneral Service Lin			nd Address of Facility	Afin- Peter	13 Fungal	Home
		-total W. Ku	IW	2284	Adam Clays	on Powe	11 Blod, NY	NY 10030
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause on	each line.	th. Do not enter the mod	e of dying, such as cardia	c or respiratory arre	st, shock, of heart /	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence	of):				Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):				
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Box 68760, eath certificate be the attending physicited for use as the buring of for use as the buring of for use as the buring the buring of for use as the buring of for use as the buring of the bu	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		th 3 Ectopic preg	nancy	23d. Date of delivery Month D	ay Year
x 68 h certi tendin	iciai	past 12 months?	4 Pregnant at time of o			ranoy	World S	
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s, P.O.	by P	Part II. Other significant condition	s contributing to death but not	resulting in the underly	ng cause given in Part I.		pacco use contribute to t 2 ✓ No 3 Prob	
ords, F v requires s been sign						24a. Was a		opsy findings available
COFC law re has be	Completed					autops perforr	y prior to o	ompletion of cause of
tal Reco	Ş					1 ✓ Yes 2	No 1 Ye	s 2 No
Vital ysician: his certifi director,	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Chec		Residence 6 V Other	Scene
Division of Vital Records, rat or Attending Physician: The law requirers after cleath. "In Director: After this certificate has been si led in by the funeral director, page 2 should b	P.	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
ion (tendin eath.	ţi	1 Natural 5 Pending 2 Accident Investig		FOUND: 0403 hrs	1 Yes 2 ✓ No	Passenger e	jected from vehicle	e in collision
ViSi or Att fter de Direct in by	<u>i</u>	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury - At		ry, office building, etc.	28f. Location (St or Town, St	treet and Number or Run	al Route Number, City
Division Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide determine	ned (Specify) Major Roa	ad / Highway		I-81 NB, exit 6/	A, Hagerstown, MD	
王 4 年 9			ician: To the best of my knowle					
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner as stated. We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner as stated.								
O.C.M.E. February 12, 2010								
On V		30 Name and address of person wh	no completed cause of death / Ite.	m 23a)				
21			istant Medical Examiner		et, Baltimore, MD 21	201		
	W.U	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				
Regist	rar	FEB 1.6 2010	Phonon B.	market				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George Edward Holtzner February 12, 2010 10:30 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 712 Kent Avenue Catonsville Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 220-07-8430 1**⊠**M 2□ F Months Days Hours Min. 88 Director Sept. 26, 1921 Maryland Usual Residence of Decedent the Maryland f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐Yes 2 XNo MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 712 Kent Avenue 21228 Funeral IISA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after leath and Mental Hygiene. 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Manany injury or other traumatic event, the Manan College (1-4or 5+) Elementary/Secondary (0-12) Truck Drive 0i117. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James B. Holtzner ပ Mary Olivia Holman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Holtzner Daughter 712 Kent Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) Encombment Crest Lawn Mausoleum 2/19/2010 Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. gnature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Metasta 116 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. icate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | **3** | **6** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۴ 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature a nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day,

Baltimore MD

2010

amer

Year)

30. Natile and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 Susan Francis Holmes 6:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) 50 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, ^{Year)} 1960 1 □ M 2 🗓 F Months Hours Mary Land Director 214-74-9273 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 1009 Plover Drive 21227 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Rrovider Own Business 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Latorre Shirley Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Holmes - Husband 1009 Plover Drive, Halethorpe, MD 21227 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Bunial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Atlantic Crematory 2-9-2010 Glen Burnie, Maryland f Juneral Servi 2. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Medical Metastatic ancer disease or condition ears resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Month Pregnant at time of death 5 the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Mellitus 2X No 1 🗌 Yes 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 68286 2010 20

State Registrar 31. Date filed (Month; Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Dep	partment of Health and N ertificate of Death		ene2010 03671
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Leonora Elizabeth Hammel		2. Date of Death Month February	Day 2010 3. Time of Death 7:50 A _M
4.	Examin		4a. Facility Name (If not institution, give street and number) Glen Burnie Health & Rehab.	4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 217–16–7225 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 7. Age (In	Months Days Hours Min.	8. Date of Birth (Month, Day, You March 7, 1	
	e Maryland Ba-f show Uffed of	Director	MD 10b. County 10c. City, Town or l MD Anne Arundel G1	ocation en Burnie		10d. Inside City Limits 1 ☐ Yes 2√∑ No
:	th with the	al Dìre	10e. Street and Number 252 Margate Drive	10f. Zip Code 21060	10g	. Citizen of What Country? U . S.A.
15-0036	permit. Fagges I and 2 should be filed within 72 hours after death with me maryland beauthent of Health and Mental Hygiene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Giver Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
0-61212	within 72 ho jiene. r than "natur the Modical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) etail Advertising	ina 1	b. Kind of Business/Industry
yland	ould be tiled I Mental Hyg harked othe hatic event,	To Be C	17. Father's Name (First, Middle, Last) Joseph V. Yingling	Elizab	e (First, Middle, Mai eth Monath	
e, Mar	and 2 sn lealth and m 27 is rr her traum		Alan Yingling/ Nephew 252	ling Address (Street and Number or Rur Margate Drive, Gle	n Burnie, M	D 21 0 60
aitimore	t. Fages I rtment of F tant: If ite ijury or ot		4 ponation 5 Other (Specify)	d Cemetery 2/17	/2010 F	c. Location - City or Town, State Parkville, Maryland
מ	Depar Import any ir			22. Name and Address of Facility Evans Funeral Chape 8800 Harford Road,		
	hysician /Medical ixaminer		/23a. Flart 1. Enter the disease, or complications that caused the death. Do not enhock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (on s a consequence of):	nter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
8/60,	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):			
O. BOX 68	attending por use as	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ecords, r	en signed by the audit be detached to	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobad	cco use contribute to the cause of death?
The Great	h. After this certificate has been s funeral director, page 2 should	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? ÎNo 1 □ Yes 2 ▷ No
VILA	is certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other:	h (Check only one) me 5 ☐ Residence	ee 6 ☐ Other (Specify)
SION OF	er death. ector: After th by the funeral	Certification; T	27. Manner of Death 1 SNatural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		28d. Describe how	
יין אַנּיין אַ	ours after d eral Direct	1 1	4 Homicide determined 286. Place of injury - At nome, farm, s building, etc. (Specify)		City or Town, S	
U Hoen	within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal continuous continuou	th occurred at the time, date and place, nvestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
λ ^k	To	2	29b. Signature and fitty of certifier	29c. License number D 3 8 9 5 8		. Date signed (Month, Day, Year)
		te	30. Name and address of person who completed cause of death (Item 23a) (Type Duke Leef Single South 208 31. Date filed (Month Day Year down 1/32. Registrar's Signature 1/32.	rain Highway	Sw Gler	/11/2010 Burnie MD 21061

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** tebruary tamie 12 ZOIO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES ALTIMO HOSPITAL Social Security Number If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, 7. Age (*In yr*s. yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**M** 2□ F Months Min. 246-30-5959 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Itimore 1 Yes 2 No Director 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21220 Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give Year or Dates: Specify: lack 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working fe. DO NOT use rethed) Elementary/Secondary (0-12) College (1-4or 5+) aster of Health and Mental Hyg If item 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) Be tamie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a BaHo. MD 21224 tamie <u>bernadine</u> Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Location - City or Town, State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licens and Address of Facility Ceens 515, Balto. Nati Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pulmona LUNS /Medical Due to (or as a consequence of): Examiner morardy Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 □ Yes 2 □ No be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records, 1 | Yes 2 | No 3 | Probably 4 | Onknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? certificate 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and fitte of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 900 CATONAVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:50 AM tarrism 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Choice Buckinghum Adam Stown
If Under 1 Year If Under 24 Hrs.
Pays Hours Min. -6 2 denilla 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 6, 1921 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1**ĕ**M 2□F 88 578-09-8479 Yrs. Washington, D.C. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Intent of Heelth and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Items 23e or 28e-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other then "natural", or items 23e or 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Maryland Frederick Adamstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 21710 3370 Upland Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Affiled Polices! 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Colfege (1-4or 5+) 5+ Elementary/Secondary (0-12) Administrative Law Judge Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Charlotte Tysver Frank Edward Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 New Mark Esplanade, Rockville, Maryland 20850-2732 Nancy Wood/Daughter other Baltimore, 20b. Place of Disposition (Name of Mont gome ry) Date 20a. Method of Disposition 20c. Location - City or Town, State February 9, 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State ö permit. Page Department of Important: if eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc. 2010 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 Buu West Montgomery Ave., Bethesda, Maryland 20050 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonam Physician Fibrosis disease or condition resulting in death) /Medical Due to (or as a conseque of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 ☑Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: P 1 ☐ Yes 2 K No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058726 2-8-10 30. Name and ad ss of person who completed cause of death (Item 23a) (Type, Print) 3000-D Ventrie Ct. Warren witte Myerrille MO 21773 32. Registrar Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rel ZUIC /Medical 4a. Facility Name (If not institution, give street and number) ty, Town, or Location of Death 4c. County of Death Examiner Randallstown **Baltimore** Seasons Hospice of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Hours Min. 1 □ M 2 🖵 F Days Director 212-44-4455 64 Jan 5, 1946 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Exprinter must be notified at Director Baltimore **Baltimore** Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 1603 Elligson Road items 23a 21237 U.S.A permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. ģ 3 →Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Correctional Officer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Wiley Cleveland Scott ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Elligson Road Baltimore, Maryland 21237 Nicole Holly or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury (02/16/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Š Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimere, Md 21 23a. Part 1. Eyler the disease, or complications t t caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** ncel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. g Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Ves No certificate 1 ☐ Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 🛰 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Spe Certification: To funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. Director: ,d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Maryland

Black

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 No

29d. Date signed (Month, Day, Year)

Year

1 DXYes 2 □ No

Division of Vital Records, To the Hospital

> 16 31. Date State 2010 Registrar

who completed cause of death (Item 23a) (Type, Print)

within 24 hours a

Medical

29a. Certifie

(Check only one)

29b. Signature and title of

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Rose Idzi P^{M} 11:42 February 8,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oakcrest Care Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

Aug. 21, 1917

Pennsylvania Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1□M 2💢 🕱 218-09-233 Yrs 92 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the "Assical Examinar must be notified at 1 ☐ Yes 2 ☐ XNo Director Parkville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8800 Walther Blvd. Apt. 127N. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ▼ No Specify: white Completed by 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Seamstress 8 and ; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F 2 should be ပ <u>Joseph Pavone</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Rolling Knoll Drive-Bel Air, Maryland Health a Michael M.Idzi-son Pages 1 and permit. Pages 1 and Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Stanislaus
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 tolo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASC V.D disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lissass or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): the attending physician ned for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 1 □Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has t 24a. Was an autopsy performed? After this certificate 2 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD#

WALTher Blad

2-9-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fh g900 2-16-10 vt

Amend 20a-b, Per fn g901 3/2 10 TI ent of Health and Mental Hygiene

Certificate of Death

Reg. No. For State Registrar 03676 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia Day Year Irvino 650 PM 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Maryland Medical Center Baltimore, MD N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Hours Min 1961 48 Yrs. Maryland **Director** 219-84-1717 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2400 Winchester Apt. 21216 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Grade Self Employed Day Care Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Jackson Walter Irving 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 N. Grantley St., Baltimore, MD 21229 Norman Jackson (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt.cenzinosiencienietherniee) 2/22/2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign at re of Fun al Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD wand runi 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Esophagal - aorte fistula
Due to (or as a Disequence of): disease or condition resulting in death) 0 min Medical Examiner una carcinon year Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 1 🗌 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/31/2010 1659530533 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzanne Siefert MD Baltimore, MD 21230 S Greene 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 8 RITA CATHERINE **JAROWSKI** ,2010 02P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X Months Days Min. (Month, Day, Year) Director 216-03-9082 90 -1919 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD BALTIMORE ROSEDALE 28a-f 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8123 CALLO LANE 21237 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc Completed by 1 Never Married 2 Married Yes 2X No filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: WHITE Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 6 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be WILLIAM BACHMANN ELSIE (BISHOFF) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JOHN A. BROOKE/P.R. 1719 GOUGH STREET BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it ₽ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) SACRED HEART JESUS 2-13-10 BALTIMORE, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ROSEDALE, 1211 CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition END STAGE DEMENTIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of; Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide M Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗶 Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

ó

FEBRUARY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02 Month Physician/ 08^{Day} 2010 M Johnson 0410 Harvey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Co. <u> Gilcrest Hospice</u> Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 50 Months Days 1 XM 2 - F S.Carolina Director 217-54-1545 60 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location Examiner must be notified at Director 28a-f 1 X Yes 2 No Baltimore MD N/a 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2004 W. Fayette Street 21223 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🔁 No ō þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natural raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) City Of Baltimore Westport Yard <u>12th Grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robinson Johnson Sr. Emma Moscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau 2004 W. Fayette Street, Baltimore, MD 21217 Geraldine Johnson(Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Star Cem. 02/15/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Western Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee illiam 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Bladder Physician/ Canas disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo 5 Other (specify) Month Year Day ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 2 🗌 No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗖 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 K Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I CRNP K149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, MD 21136 Grant 6701 H. Charles

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 Year obert L Jones 1122 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours (Month, Day, Director VIRGINIA 231-66-9521 59 MAR. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Completed by Funeral 23a 2311 MADISON AVENUE U.S.A. items 2 death 12. Was Decedent Ever in U.S. Was Deceue.
Armed Forces?
Ves. 2XX No. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION KEITH FLANNIGAN & SON 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important. If item 27 is marked, any injury or other traumestimany injury or other traumestimans. ᅙ EDWARD JONES ROSA JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2311 Madison AVe., Baltimore, Maryland 21217 Sherree Kelly-Jones/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ZION CEMETERY 02-15-10 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Type B Aortic Dissection disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hiatal Hernia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 X No ဂ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Box 68760

P.0.

Division of Vital

Matthew Folstein MD University of Maryland Medical Center 225 Greene St Baltimore Md 21201

1952536674

29d. Date signed (Month, Day, Year) 02.03.2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical ility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Season's Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/23/1951 7. Age (In vrs. last birthday **Funeral** Months 1 □ M 2 🖾 F 217-52-7353 Director 58 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show s 23a or 28a-f show Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3115 Belmont Avenue 21216 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or items other traumatic event, the Wedical Examination Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 21 No Specify \$ If Yes. Give 3 Widowed 4 X Divorced Year or Dates Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) 11th Grade College (1-4or 5+) House Keeper Sinai Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John F. Johnson Sr. Dorothy E. Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nirmala Johnson (Daughter) 3326 Edmondson Ave., Baltimore, MD 21229 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/16/10 | Baltimore, MD King Park Mem. 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Ö 1 □Yes 2 □No been signed by the should be detached 9 Unknown ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn of Vital 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 ♣ this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred Hospital or Attending Division Natural 2 Accident 5 ☐ Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of ce ne and address of person who completed cause of death (Item 23a) (Type, Print) BOB State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Denice Ceola Jones 8,2010 06:08a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days Min. Months 08-16-1954 Hours **Director** 577-74-1343 Washington, DO Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits DC Washington 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 4908 Fitch Place, NE 20019 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Black White etc. "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify. 3 ☐ Widowed 4 🕅 Divorced Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Accounting Supervisor Federal Government Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mark Tatum Wilhelmena Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,\,20772$ Christine Cuffey -Daughter 12606 Midstock Lane, Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Memorial: 02-15-10 Waldorf, Maryland 22. Name and Address of Facility Ronald Taylor II Funeral Hm 108 W. North Avenue, Baltimore, Md. 21201 Signature II Funeral Service License 108 W. North Avenue, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final Onset and Death Pinysician/ cardia 0 disease or condition Medical resulting in death) Due to (or as a c quence of). Examiner Sequentially list conditions, ner Due to (or se a consequence or) cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown as been signed by t 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Henrich Mar Hylere in 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page performed? Yes 2 No this certificate after death.

Director: After this certification by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral C Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and cer 29c. License number D0055120 2010

Registrar

DHMH 17 Rev 7/2009

avena

Suite 310

Was hing ton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23 Southern

32. Registrar's

kinen Wil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 03682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2010 Year Feb. Webster Johnson-Bey 9 439 Arthur Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X□ M 2 □ Hours Min. 10-28-1957 Indïäna Director 315-70-665 Usual Residence of Deceden show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Hyattsville MD PG 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 Funeral 4410 Oglethorpe St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ò 1 Never Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) & G Warehouse Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Arthur W. Johnson-Bey Sr. Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 Oglethorpe St. #310 Hyattsville, Elizabeth Johnson-Bey/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cem. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. 02-19-2010 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of FacilitiRonald Taylor II FH 0583 Middleport Ln. White Plains, 23. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Atheroscleratic Coronauy Immediate Cause (Final Artery Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Exami s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation 6 \square Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 52326 0 2010

State Registrar Dr. James K. Lightfoot, M.D. - 7600 Carroll Avenue, Takoma Park,

/32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 = State Registrar	n wa yan	-	rtificate of L		-	Reg. No	0 03683
	Physicia		Decedent's Name (First, Middle, Last) PAULINE JEANETTE JANA	SEK				2. Date of De		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and num 9104 Grant Avenue	nber)		4b. City, Town, or Laurel	Location of Death		4c. County of D	Peath
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th 9.	Birthplace (State or Foreign
	Director		233-58-8832 1 LJ M 2 XX Usual Residence of Decedent	70	Yrs.			January	7 1940	Country) West Virginia
	aryland a-f sho fied at	Director	10a. State 10b. County Maryland Howard	10c. City Lau	y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ ₩o
	the Minor 28	Į Į	10e. Street and Number	Lau	rer	10f. Zip Code			10g. Citizen of What	
	th with ms 23e must b	Funeral	9104 Grant Avenue			2072			U.S.A.	_
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	Armed Fo	2 XX No ∕e		Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, Yhite, etc. White
Baltimore, Maryland 21215-0036	ithin 72 ho lene. r than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade completed, Elementary/Seconday (0-12) Grade 12 College (1		(Give life. D	dent's Usual Occup kind of work done o O NOT use retired) .stant Mai	luring most of wor	king	16b. Kind of Busine	
nd 2	filed w tal Hygi d othe event,	To Be	17. Father's Name (First, Middle, Last)		11001	Journal Ha	18. Mother's Nan	, ,	Maiden Surname)	11011
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nore	ge 1 ar nt of He t: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	State Ce	emetery, cren	sition (Name of natory or other plac	· .	Date	20c. Location - City	,
altin	permit. Pa Departme Importan any injury once.		4 ☐ Donation 5 🛛 X ther (Specify) Entomb 21. Signature of Funeral Ser\(\text{ice}\) ice sicensee	ment M		idge Mem Domardage				, Maryland
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	h sician/ Medical			ch line. kinson':	s Dise		g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death Vears
لمر	Examiner	L	Sequentially list conditions, b.	(or as a consequ	ience of):					
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68760	rrtificate ling phy e as th		IF FEMALE:							
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ords	w requir s been s	Completed						24a. Was	an 24b. Were	autopsy findings available
Rec	sician: The law certificate has irector, page 2 s	Com						autop perfo 1 🗌 Yes	rmed? death	to completion of cause of ? Yes 2 XXVo
ıta	iysician; is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 XXNo Hospital:		FB/0	Othe	ace of Death (Chec			
Division of Vital Records,	nding Physath. r: After this ne funeral di	Certificate: To	27. Manner of Death 122Natural 5 ☐ Pending 2 ☐ Accident Investigation	Inpatient 2 Inpati	28b. Time of injury	28c. Injury work	at		dence 6 Other (Spoots) Ow injury occurred	secify)
Divisi	Pospital or Atteno 24 hours after deat Funeral Director: leted filled in by the	-	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildi	of Injury - At hor ng, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
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	To the Complex		29b. Signature and title of sertifier	ms		29c. License	number		29d. Date signed (Mo	·
)	2		30. Name and address of person who completed caus	se of death (Item	23a) (Type, P		25422		February	15, 2010
l	01		Robert Y. Maggin, M.D.	13952 Ba	altimo	re Avenue	Laurel	, Maryla	and 20707	
	Stat Registra		FEB 1.6 2010	egistrar's Signatu	A So	ald				

Box 68760. C Division of Vital Becords

			For	State	of Mai	-	partment of			lental Hy	giene		
			1 - State Registrar			<i>C</i>	ertificate of	Death)		Reg. No.	2010	03684
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Wilma James 4a. Facility Name (If not institution	n who street and r	u ma ha el		4h City Toyun	and another	of Dooth	Januar	-	5, 2010 County of Death	2:22 PM ^M
	Examin	er	603 S. Ann St				4b. City, Town, Balti		oi Death		40.	County of Death	
	Funeral		5. Social Security Numberunk	6. Sex		(In yrs. last birthda	y) If Under 1 Year	r If Under		8. Date of Birt	th .	9. Birthp	lace (State or Foreign
	Director			1□M 2 ∏ F		74 Yrs	Months Days	Hours	Min.	(Month, Da Sept 30	0, rear)	935 Tenne	
	nd ,		Usual Residence of Decedent		<u> </u>					•			
	aryla shov	=	10a. State 10b. County			10c. City, Town or Ra1	timore					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	ect	10e. Street and Number				10f. Zip Code				10a Citi	izen of What Coun	
	with yard	ö	603 S. Ann St	reet #502			Tot. Zip Gode	21231			rog. Oil	USA	uy:
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show Is marked event, the five field Evaluting or items to rediffed at	Funeral Director	11. Marital Status	12. Was De	cedent Ev	er in U.S. 1	3. Was Decedent of If Yes, specify Cu			ecify Yes or No	-	14. Race - Americ	an Indian,
0	or ite	F	1 ☐ Never Married 2 ☐ Marı	ried Armed	orces? 2 X No		If Yes, specify Cu 1 ☐ Yes 2 🕅 No			Rican, etc.)		Black, White,	
3	ral",	d by	3 ☐ Widowed 4X Divorced	If Yes, (Year or	Dates:		ILITES ZIZINO	o Specify	/:			Specify: Whi	.te
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7	within ene.	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)	life	n. DO NOT use retir cler	/				banking	
7	Hygi Hygi ther ent, u		17. Father's Name (First, Middle,	Last)					ner's Name	(First, Middle,	Maiden		
8	d be ental ked o	To Be	William G. Ba	,						Quails			
, L	shoul ind M i mar umat	ř	19a. Informant's Name/Relations	hip (Type. Print)		19b. Ma	illing Address (Stree	et and Numb	ber or Rura	al Route Numbe	er, City o	r Town, State, Zip	Code)
Š	atth a	l,	Charlotte Ann	Huemmer/	sist	er 603	S. Ann	Street	#416	6 Balti	more	,MD 212	31
ני ב	of He of He Item		20a. Method of Disposition			20b. Place of Dis	position (Name of rematory or other pl	lace)	D	ate	20c. Lc	ocation - City or To	wn, State
	Page nent ant: If ary o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🛣 Other (S	3 □Removal from pecify) in St	n State Late	,		,					
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other traumatic event, the involved Exal, find out to other than the involved Exal (in the involved Exal).		21. Signature of Funeral Service	Licensee	1/1		22 Name and Add State An	ress of Facil	lity Boar	d 655 V	J. Ba	altimore	Street
<u> </u>	20E # 9		Juny	MAN			Baltimor	e,MD	21201				
			23a. Part 1. Evter the diseas 1, or shock, or eart failure. List	complications that only one cause or	caused the	ne death. Do not	enter the mode of d	ying, such a	s cardiac o	or respiratory a	rrest,		Approximate Interval Between
·	Physician	1	Immediate Cause (Final disease or condition	a	A-5	モレカ							Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a	consequence of):							
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3	diffication of the second of t	ledi											
	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c			3 ☐ Ectopic pregnar	ncv				23d. Date of delive	. ,
,	at the dea by the al tached fo	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		gnant at t		5 ☐ Other (specify)					Month	Day Year
	hat th	Ph	Part II. Other significant condition	one contributing to	death but	not resulting in the	underlying cause o	iven in Part		23e Did to	obacco i	use contribute to the	ne cause of death?
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	: The lav cate has page 2 s	du.								24a. Was autor perfo		prior to condeath?	psy findings available mpletion of cause of
3	in: TI		25. Was case referred to medical					00 Di-	4 D 41	1 □Yes	2 No	1 ☐ Yes	2 No
-	Physician: The r this certificate Ir al director, page	o Be	examiner?	Hospital:] Inpatient	2 ER/Outpa	ient 3 DOA O	thor:	lursing Ho	me 5 Resi		6 ☐ Other (Specif	
5	g Phy er thi	<u>ان</u>	27. Manner of Death	28a. Dai	e of Injury	28b. Time	of 28c. Inj	ury at		28d. Describe I			y/
5	arth. or: Aff	atio	1 Natural 5 ☐ Pendin	gation	onth, Day,	Ye <i>ar)</i> Injur		ork? □Yes 2□	□No				
2	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could of determ	inod Zoe. Flat	ce of Injury	/ - At home, farm, (Specify)	street, factory, office	9	2	28f. Location (S City or Tox		nd Number or Rura	l Route Number,
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	To the Hospital or Atending Phywithin 24 hours after death. To the Funeral Director. After this completely filled in by the funeral or	Medical		Examiner: On the	basis of e	examination and/o	eath occurred at the investigation, in my						
	thin 2 the orthodorum	Med	29b. Signature and title of certifie		nner state	na. N	29c. Lice	nse number		T	29d. Dat	te signed (Month,	Dav. Year)
\	F > F 8			-1-1		La vo	Do	024	130=	3	2/	3)10	**
7			30. Name and address of person	who completed ca	use of dea	th (Item 23a) (Typ	e, Print)	7 7 2	22.	2 00	. 12	1 1	
			3509 15	phan	1	12-1	かりり) 44	del 2		()	1 . [Mar
	Star Registra		31. Date filed (Month, Day, Year)		Hegistrar'	s Signature	CAN						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 7:30 PM John W. Jennings Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Villa Nursing Baltimore Baltimore Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth 1928 **Funeral** Months Davs Hours (Month, Day, Director 215-22-5916 Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If items 23a or 28a-f sho important: If item 25 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 409 South Smallwood Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home improvements Handyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Dohring Thomas Joseph Jennings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
409 South Smallwood Street, Baltimore MD 21223 19a. Informant's Name/Relationship (Type, Print) Delores E. Kenneally-sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Literman, 4 Donation 5 Other (Specify) Burial 2 Cremation 3 Removal from State Crestlawn Mem Gardens 2-10-2010 Marriottsville, MD 1. Signature of Fur eral Service Licen. 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road, Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ anc disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 💢 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 W Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE MD 21229 NILK ENS 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G900, 2/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 03686 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PEBRUARY Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death Age (In yrs. last birthday) If Unde 24 Hrs Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 21 🗸 F Months Hours Month, Day Director Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21013 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 1 No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE 3 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Dav Year 1 Yes 2 ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy funeral director, page 2 performed? Yes 2 X No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 2 **X** No ပ္ 1 Yes 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident 2 No Investigation after death Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 29b. Signature a 29c, License number 29d. Date signed (Mønth, Day, Year) 20 30. Name and ss of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

FEBRUARY

JUERGENSEN

IRENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February Marjorie L. Jones 2010° 12:25 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Pickersoill Retirement Community Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) EC. 3, 1916 1 M 2 X F Days 212-36-3499 New York Director Dec. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Timonium 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Rd. Apt. 416 21093 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore and Harford Elementary/Seconday (0-12) College (1-4 or 5+) Teacher County Be 17. Eather's Name (First, Middle, Last) John L. Gorman 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Louise Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae Janet Wickens/ Daughter 17 Essex Circle Drive, Shrewsbury, PA 17361 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Du laney Valley Memorial 02/15/2010 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee 8800 Harford Road, Parkville, Maryland 21234 23a. Pur 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final middle cerebral Artery Physician/ disease or condition Medical resulting in death) Due to (or als a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a detached f 1 ☐ Yes ∠ € 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 724a. Was an certificate has be irector, page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. work? 1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier w

State Registrar

Box 68760

P.O.

670

Registrar's Signature

30. Name and address of person who completed cause of death (Hom 23a) (Type, Print)

BMC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 03688 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eugene Jones Darrel February 2010 7:03 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, May 3, 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours 1 □XM 2 □ F Country) Director 236-42-0875 Yrs. 1929 Rennsboro. Usual Residence of Decedent 23a or 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk 1 Tes 2 XNo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3419 Sollers Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1X Yes 2 No
If Yes, Give þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Steelworker 12 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Lillian Virginia Rampmeyer Darrel Eugene Jones permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Cornwall Road, Dundalk, Maryland Mark Jones son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 XBurial 2 Cremation 3 Removal from State Dundalk, Maryland 4 Donation 5 Other (Specify) Oak Lawn Cemetery 15, 2010 21. Signature of Futeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ances months Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin ng physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Yes 2 NO Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide To the Hospital or Attending 5 Pending Division 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 2010 101 30. Name and addre who completed cause of death (Item 23a) (Type, Print) N. Charles hacles MD 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 05:04 PM MARILYN JACOBSON 2010 ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Date of Birth (Month, Day, Year) 06/20/1926 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F 214-20-7352 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machall Evarinter must be notified at once. 1 ☐ Yes 2 X No by Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 PEREGRINE COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □ Yes 2 No If Yes Give Specify: 3 X Widowed 4 ☐ Divorced Year or Dates WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRIS JULIA COHEN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 PEREGRINE COURT, BALTIMORE, MD 21208 LEE JACOBSON / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 2/15/2010 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. art 1. Enter the disease, remplications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erforated Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner heymon.a Sequentially list conditions, it any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 \(\text{\text{Nursing Home}}\) \(5 \sup \) Residence \(6 \subseteq \text{Other}\) (Specify) \(\text{Line FT Hosp. \text{ definition}}\) 2 NO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FEB 1 6 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please	· Type or Print in Black Indelible Ink. Ensure All Copies Are Lo	egible.	2000
	• Type or Print in Black Indelible Ink. Ensure All Copies Are Louis State of Maryland / Department of Health and Mental Hygiene	2010	0303
	0 (15) (50 ()		

			1- For State Registrar				C	ertifica	te of	Death				Reg.	No.			
	Physi		1. Decedent's	Name (First, Mic	ldle,Last)								2. Dat	e of Death	ay Yea	r	3. Time of	
Me	dical Exa	nine	Lamo		nes		·						Feb	ruary 3,	2010		0854	hrs
•			4a. Facility Na Sinai Ho	me (if not institut	ion, give st	reet and n	umber)		4	b. City, Tow Baltimo		ocation of De	eatn		4c. County o	or Death		
			5. Social Secu		6. Sex		7. Age (In yr	rs last hirtho	day)	If Under		If Under 24	Hrs 8 D	ate of Rinth(N/A MM/DD/YYYY	9 Birt	holace (Sta	ate or
	Funera Directo					ء □ -		13. 143t DITTIC	• /		Days		Min.			Foreig	n	
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	he M	Director	2905	Fallst	aff l	Road			i	212	กด				USA			
0	with 1	a la	11. Marital Sta			2. Was De	cedent Ever in	n U.S.		Decedent	of Hispa	anic Origin?			14. Race		can Indian,	Black,
5796	leath r iten	uneral	1 X Never I	Married 2	Married 1	Armed F	forces?		If Ye	s, specify C	Cuban, N	Mexican, Pu	erto Rican,	etc.)	White	, etc.		
1	after aft.	by F	3 Widow	ed 4 🔲 🗅	ivorced If Y				1	Yes 2 X	No	specify:			Specify:	Bla	ck	
5	nours	ed t	15. Deceden	's Education (Sp								n (Give kind OO NOT use		ne 16	Bb. Kind of Bu	siness/li	ndustry	
	72 II 72 I	Completed	Elementary	Secondary (0-12	2)	College (1-4 or 5+)		Ü	TAT 3			ŕ		TT 1	^		
	5-003(led within Hygiene. other tha		12 Father's N	ame (First, Midd	o Lost)			L1	ne	Work		Mother's N	ama /First	Middle Mai	Unde		rmou	ır
	215- be filed antal Hyg	Be C		•		~					'							
	212 ald be Ment	B O		ie B. s s Name/Relation				19b.	Mailing.	Address (Street a	Frie		Jones	r, City or Town	n, State,	Zip Code)	
	MD 21215-0036 12 should be filed within 7 tith and Mental Hygiene. n 27 is marked other than		Frie	da Jon	es			29	05	Fa.11	sta	ff R	oad.	Balti	more,	Md.	212	09
	e, P l and Health		20a. Method o	Disposition				Ob. Place of cremator	Disposit	ion (Name			Date		0c. Location -			
	nor rages rat of rat: If			2 X Cremation 5 Other		Removal f		etro			77 77	9	/5/2	010	Caton	ani	110	Md
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show			uneral Service		-	, jui	etro				f Facility	C F11	010	Serv	300	DA	Mu.
	E E E		7.	leil	1	7	tel)	[L3	SUU E	uta	IM PI	ace,	ватт	imore	, IV.	id.	21217
	Physicia			er the disease, of			caused the de	ath. Do not	enter the	e mode of c	lying, su	uch as cardia	ac or respir	atory arrest,	shock, or hea	ırt		nate Interval Onset and
	.Examine	_		use (Final diseas			clerot	cic ca	rdic	vascu	ılar	dise	ase c	omplic	cated b	У		eath
1	·LXamme		or condition re	sulting in death)	Due	e to (or as	a consequenc	e of):COC	aine	use								
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		Examiner	cause. Enter	Jnderlying Caus ury that initiated	e			,										
21	- R	K		g in death) Last		e to (or as	a consequenc	ce of):										
k	760, cate be executed physician and	<u> </u>	XUNPEN		¬₫.	MENDED							-					
	o, e be e	Medical		JED				27 , per	mE,	g900	2/2	2/10	ΓT		00 D (
	8760 tificate b			dent pregnant in		23c. If yes,	outcome of probinth	regnancy 2	Feta	al death	3	Ectopic pre	gnancy	ļ	23d. Date of Month		ay	Year
	Box 68 e death certif	sician/	past 12 m			4 Preg	nant at time of			er (Specify								
	Bo the au	Phys	1 Yes 2			9 Unkn												
	Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending	by P	Part II. Other	ignificant cond	litions co	ntributing t	o death but no	ot resulting i	in the un	iderlying ca	iuse giv	en in Part I.	23		cco use contril 2 No 3		_	
	S, F	ed				_							-	2-17-2-3-1	- 7500 ==			-
	ord w req	Completed											_ 24	la. Was an autopsy	р	rior to co		gs available of cause of
	Sec The la	E											1[performe Yes 2 ▶		eath?	s 2	No
	ian:	Be C	25. Was case examiner?	eferred to medic						26.		f Death (Che	eck only on	e)				
	of Vital ing Physician: After this certif	2	1 🗸 Yes	2 No	Hosp			✓ ER/Outr					rsing Home		sidence 6			
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that t rs after death.	Ë	27. Manner of 1 X Natura			28a. Date (Mont	e of Injury h, Day,Year)	28b. Tir	me of Inj	1		at Work?	28d. D	escribe how	injury occurre	ed		
	SiOr vitend death ctor:	ati (2 Accide	F6	nding estigation				12			s 2 No	-					
	Nor A	Certification:	3 Suicid		uld not be ermined		ce of Injury - A	At home, farn	n, street	, factory, of	fice buil	iding, etc.		Town, State	et and Numbe e)	r or Rur	al Route N	umber, City
0.4	ospits hours	၂ ပိ	4 Homic 29a. Certifier	de		(Specify,		J - J J H							\d			
N	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate	dical	(Check only		aminer: Or	the basis	of examinatio) and manner I place, and du			
pen	5 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Mec	29b. Signature	and title of certi		d manner	stated.			29c. L	icense r	number		25	9d. Date signe	d (Mon	th, Day, Ye	ar)
	1		Q1	in 2	400-						D.C.M	.E.		F	ebruary 4,	2010		
			30. Name and	address of perso	n who com	pleted cau	se of death (It	tem 23a)										
			Ana Rul		ssistant I	Medical	Examiner	111 Pe	enn St	reet, Bal	ltimore	e, MD 212	201					
		State		EBI6	2010	3 R	egistrar's Sigr											
	Reg	istra	'	V	PAIN	A		7	AL AS									

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amend #20 tate of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of iv	iai yiai iu	•	tificate of L	Death		Reg. No. 2	LO	03691
	Physicia	n/	1. Decedent's Name (Fi	rst, Middle, La						Date of Dea Month	Day	Year	3. Time of Death
	Medic	al	4. Farility Name (if mat	institution also) Joh	nson,		Landau of D. offi		Feb 2, 201		9:06a ^M
	Examin	er	4a. Facility Name (if not	institution, givi	Stella Maris			4b. City, Iown, o	r Location of Death	onium	4c. County		imore
	Funeral		5. Social Security Numb 218–46–	er 6. S	Sex 7. Ac	ge (In yrs. las:	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign
	Director		218-46-50)66	1 □ x M 2 □ F	61	Yrs.	Months Days	Hours Min.	(Month, Day	2 1949	Coun	Maryland
	how how	ř	Usual Residence of Dec 10a. State 10	b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	arylar a-f sl	ecto	Maryland		N/A	,			Baltimore				1 ☑ Yes 2 ☐ No
	or 28	ρ	10e. Street and Number					10f. Zip Code			10g. Citizen of W	/hat Cour	ntry?
	s 23a	Funeral Director	5912 Highga	ate Drive					21215			U.S.	A .
Ē	death r item ner n	Fur	11. Marital Status		12. Was Decedent Armed Forces?	?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	an Indian, etc.
, a 336	al", ol	d b	1 ☐ Never Married 3 ☐ Widowed 4 ☐	• •	1 Yes 2 If Yes, Give Year or Dates.	X No	1	☐ Yes 2 ☐XNo	Specify:		Specify:		Black
9:06 a 215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed by	15	5. Decedent's B	Education	- 1	16a. Deced	ent's Usual Occup	pation	1	16b. Kind of Bu	siness Inc	dustry
215	iin 72 ie. han "	duo	(Specify Elementary/Seconda		rade completed) College (1-4 or	5+)	(Give F life. D	nd of work done on NOT use retired)	during most of work	ing		M1	ΓΔ
2010 and 21	d with tygier ther t	തി	12						Driver				
20 anc	2 should be filed withir Ith and Mental Hygiene 27 is marked other the traumatic event, the	70 E	17. Father's Name (First		Johnson				18. Mother's Nam	, , ,	uth Johnso		
2, aryl	nould I nd Me s marl		19a. Informant's Name			T	19b. Mailin	a Address (Street	and Number or Run				Code)
ŽŽ	d2shaltha altha 27is ertran		Betty Johns	on					e Drive Baltim			•	,
FEBRUARY 2, 2010 Baltimore, Maryland 21	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once:		20a. Method of Disposit		Removal from State		ce of Dispo	sition (Name of natory or other place	e) n2/15	Date / 2010	20c. Location -	City or To	own, State
EBR	Page iment o tant: If jury or		4 Donation 5			9		g Memorial F		02/08/10	Wi	ndsor l	Mill, Md.
FI Balt	permit. Departn Importa any inju		21. Signature of Funera	I Servio Licen	isee S.A.		22	. Name and Addre	,	oral Conside	DΛ		
	452.00		23a Part 1 Enter the o	Marke or con	polications that cause	ed the death	Do not ente	1300 E	Brothers Fundate Eutaw Place E	Baltimore, M	d 21217	-	Approximate
			23a. Part 1. Enter the c shock, or heart fai Immediate Cause (Fina					, alo modo or dym	g, odon do odrana	or respiratory arr	501,		Interval Between Onset and Death
	Inysician/ Medical		disease or condition resulting in death)		a. PANCREA	ATIC CA						-	-
	Examiner					4 00000							
		iner	Sequentially list condit if any, leading to imme- cause. Enter Underlyin	ions, diate	Due to (or as	a conseque	nce of):					j)j	
V	cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinju that initiated events	ry	C							\perp	
7	e execian a		resulting in death) Last		Due to (or as	a consequei	nce or):						
1760	death certificate be executed he attending physician and ed for use as the burial-transi	edic			d					-			
89	ath certifice attending p	M/m	IF FEMALE: 23b. Was decedent pre	gnant	23c. If yes, outcome	e of pregnanc	y	1			23d. Dat	e of delive	ery
Вох	e atte	sicia	in the past 12 mon 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No.} \)	ths?	4 Pregnant	at time of dea		Ectopic pregnand Other (specify) _	су		Mor	nth	Day Year
		Physician/Medical	9 Unknown Part II. Other significar			_			one in Don't I				
N. G.	es tha	by	Part II. Other significan	nt conditions (contributing to death	but not result	ing in the u	nderlying cause gr	ven in Part I.				ne cause of death?
JOHNSON Records, F	requir peen s hould	Completed								24a. Was a			osy findings available
JOE	e law e has b ge 2 s	dmo								autop _ perfor	sy p med? d	rior to colleath?	mpletion of cause of
H H	in: Th	Be Cc	25. Was case referred to	medical				26. Pl	ace of Death (Chec	1 🗆 Yes	2 X No 1	☐ Yes	2 ∐ No
LUKE Vital F	ysicia is cert direct	To B	examiner? 1 Yes 2 N	0	Hospital:	tient 2 🗆 El	R/Outpatien	Oth	er.	,	ence 6 X Othe	r (Specify	HOSPICE
of	ng Ph fter th ineral	ite:	27. Manner of Death 1 X Natural 5	☐ Pending	28a. Date of inj (Month, Da	ury 2: ay, Year) 2:	8b. Time of injury	28c. Injury	y at c?	28d. Describe ho	ow injury occurre	d	
ion	ttendi Jeath. tor: A the fu	Certificate:	2 Accident	Investigatio	he -				Yes 2 No				
Division of	l or At after d Direc	Cer	4 Homicide	determined	building, et	jury - At nom tc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S: City or Town	treet and Numbe n, State)	r or Rurai	Route Number,
Δ	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.				ysician: To the best o								
I_i	ne Ho in 24 I he Fu	Medical	(Check 2 only one) 3 X	Medical Exam Certifying Nur	niner: On the basis of rse Practioner: To the	examination a e best of my k	ind/or invest nowledge, d	igation, in my opinio leath occurred at th	on, death occurred a e time, date and pla	t the time, date ar ce, and due to the	nd place, and due cause(s) and ma	to the cau	use(s) and manner stated. ated.
1,	Vithi Com		29b. Signature and title	of dertifier	2011	0	-	29c. License	e number	2	29d. Date signed	(Month, L	Day, Year)
			1/4	XIVI	SUNT			1K14	19792		2/2/	201	0
-			30. Name and agdress										
	Stat	e	JACKIE JO 31. Date filed (Month, D			DULANI rar's Signatur		LEY RD.	TTMONTUN	I, MD 21	093		
	Registra		FEB 1	6 2010		A.	box	20					

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			For		State	of Mar		artment of I		and M	lental Hy	giene		
			State Registrar				Ce	rtificate of l	Death			Reg. No.	2010	102602
	Physicia	n/	1. Decedent's Name (Fil	rst, Middle, Las		_					Date of De Month		Year	3. Time of Death
	Medic	al					Lee Jone					Jan 29	, 2010	0540 м
	Examin	er	4a. Facility Name (if not	-				4b. City, Town, o	r Location o	Tow	eon	4c. (County of Death	imore
	Funeral		5. Social Security Numb		Center for		n yrs. last birthday	If Under 1 Year	If Under		8. Date of Bir	th	9. Birt	hplace (State or Foreign
	Director		216-42-898	85	□ M 2 X □ F		67 Yrs.	Months Days	Hours	Min.	(Month, Da Nov 1	y, Year) 0. 1942	2 Col	vintry) Virginia
	ow T	L	Usual Residence of Dec			Ι,	0- 04- T- 1							
	ırylanı I-f sh ied a	cto		•	imore	'	0c. City, Town or L		ckeysvil	lo				10d. Inside City Limits 1 ★ Yes 2 □ No
:	ne Ma nr 28g notif	Dire	Md. 10e, Street and Number		illiole			10f. Zip Code	CKCySVII			10- 04-	zen of What Co	
3	with the	ıral	2 Nutmeg Kn					Ton E.p code	210	30		rog. Citiz	U.S	•
	eath v	Funeral Director	11. Marital Status		12. Was Dec		r in U.S. 13	Was Decedent of H	ispanic Orig	in? (Spec	ify Yes or No-	1	4. Race - Amer	
o စ	tter d , or i	by	1 Never Married	• •	Armed For 1 Yes If Yes, Gir	2 🙀 No	,	If Yes, specify Cuba 1 Yes 2 X No		, Puerto I	Rican, etc.)		Black, White	
o500-c	oursa tural' al Ex	Completed	3 Widowed 4 🗆		Year or D							s	Specify:	Black
င်	72 hc n "na ledic	nple	(Specify	o. Decedent's E conly highest gra		9	(Give	edent's Usual Occup kind of work done o DO NOT use retired)	during most	of workir	ng	16b. Kin	d of Business I	ndustry
<u> </u>	vithin jene. r tha		Elementary/Seconda	ıy (0-12)	College (*	1-4 or 5+)	ine.		eacher			Ba	altimore So	hool System
ב ב	illed v	Be	17. Father's Name (First,	Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Si	urname)	
yiand	d be i	욘		Unkr	nown						ı	Unknov	wn	
Mar	shoul and l is m		19a. Informant's Name/	Relationship (7)	vpe, Print)		19b. Mai	ing Address (Street	and Numbe	r or Rurai	Route Numbe	r, City or T	own, State, Zip	Code)
2 :	and 2 lealth im 27 her tr		Denise Gordo					602 Cedar Fa	arm Driv	e Balti	more, Md.			
ָם סו	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Inopartment of Health and Mental Hygiene. Inopartment of Health and Mental Hygiene. Inopartment if frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 C		Removal from	n State	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	:e)		ate	20c. Loc	cation - City or	
	rt. Pa		4 Donation 5		**			National Park		<i>-</i> 1 <i>y</i>	02/02/10		Laurel, N	Maryland
0	permi Depar Impo any ir		21. Signature Funeral	Service Licens		7		2. Name and Addre			al Service Itimore, M	P. A.	-	
			23a. Part 1. Enter the di shock, or heart fail	idease, or comp	plications that	caused th	e death. Do not en	ter the mode of dyin	utaw Pla g, such as o	ace Ba	respiratory an	d 2121 rest,		Approximate
~P	hysician/		Immediate Cause (Final disease or condition		13	ierh								Interval Between Onset and Death
	Medical Examiner		resulting in death)				onsequence of):							Jan 3
		7	Sequentially list condition	ons,	b. ———									
7	sit s	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or linjur	liate	Due to	(or as a co	onsequence of):							
-	and Il-tran	Exal	that initiated events resulting in death) Last	y	c. Due to	(or as a co	onsequence of):							
2	physician and the burial-transit	edical		L	d									
D C	g phy as the				u									
5	yacidar, the tax hequiles that the odath certificate has been signed by the attending theretor, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent preg	TICALITY .	23c. If yes, ou	tcome of p		Ectopic pregnanc	·v			23	3d. Date of deli	very
YOU Stable	he att	sici	in the past 12 mont 1 Yes 2 No 9 Unknown			nant at tir		Other (specify)	,				Month	Day Year
; ‡	d by t		Part II. Other significan	t conditions of	ontributing to c	leath but r	not resulting in the	underlying cause giv	en in Part I		220 Did to	abaaaa ua	o contributo to	the cause of death?
, d	signe I be d	d by			on a batting to c	outil put i	iot rooditing in the	andonying dadde gil	on mr att	•				obably 4 X Unknown
cords,	peen	lete									24a. Was			opsy findings available
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	tificat or, pa	o l	25. Was case referred to	medical				26. PI	ace of Deat	h (Check	perfo	2 No	1 L Yes	2 No
VILLE	is cer direct	70 B	examiner? 1 🗌 Yes 2 🛣 No	·	Hospital:	Inpatient	2 ER/Outpatie	Othe			-	ience 6 D	↑ Other (Specin	y) Hospice
5 5	ter this neral di		27. Manner of Death	Pending	28a. Date		28b. Time o		/ at		8d. Describe h			77.13
	leath.	itica I	2 Accident	Investigation Could not be					Yes 2 🗆	No				
SIVIS	after of Direct	Certificate:	4 Homicide	determined	28e. Place	of Injury ng, etc. (S	- At home, farm, st Spec <i>ify)</i>	reet, factory, office		2	8f. Location (S City or Tow		Number or Rura	al Route Number,
To the Hoenitel or Attending Division: The Jaw requires that the death cartificate he accounted	within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral process.	Medical	29a. Certifier 1 🔲 0	Certifying Phys	ician: To the b	est of my	knowledge, death	occured at the time	, date and p	lace, and	due to the car	use(s) and	manner as stat	red.
A d	in 24 he Fu	Med	(Check 2 Nonly one) 3 X	Medical Exami Certifying Nurs	ner: On the base e Practioner:	sis of exam To the bes	nination and/or inve st of my knowledge,	stigation, in my opinio death occurred at the	on, death oc e time, date	curred at t and place	he time, date a , and due to the	nd place, a e cause(s) a	and due to the ca and manner as s	ause(s) and manner stated stated.
Ę	Z A S E S E S E S E S E S E S E S E S E S		29b. Signature and title of		100	2		29c. License			- 1		signed (Month,	
			you		uf, CK				1919	4		Jan	nay 20	1,5010
			30. Name and address o	Grant,				Print) St, Tows	orna M	N	DIDAY			
	Stat	е	31. Date filed (Month, Da	Yana			Signature	30	on, T	· CV	a laco			
	Registra	r	red A	o Zytu	principal	in you	le Marie							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:53 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospitul Baltimore Year If Under 24 Hrs Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 🌠 M 2 🗆 F Min 0672271959 Mary land Director 50 218-72-8226 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1935 West Mosher Street 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 🗆 Widowed 4 屎 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Stock Employee Rite Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ellen Erainer Jones David Mayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2219 Windsor Avenue Baltimore, MD 21216 Irene Harris Ford-Grandmother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2.19.2010 Baltimore, MD Mt. Zion Cemetery Signature of Fun T Service Licens John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 Dack Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myo cardial inforction disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ for in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown Yes 2 No the 9 Unknown page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examine. Yes Hospital: 2 🗆 No Other: 욘 1 Inpatient 2 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this anner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

24 hours within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosphan

Print) D0056240 February 9, 2010 2000 W. Baltmore Street, Baltmore MO 21

(Check

only one)

32. Registrar's Signatur

State Registrar Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

1200

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month LILLIAN D. KEYS 2010 10:10P Feb. 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Baltimore Towson Manor Care - Dulaney If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 18, 1925 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Months Days 84 Maryland 219~12~6380 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Towson Directo Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21204 USA 1104 One Smeton Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes ※ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:White 1 ☐ Yes 2X No Specify 2 ¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. State Government Administrative Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Dotson Agnes America Reese 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth N. Keys, Jr. (Son) 8142 Glen Arbor Drive Baltimore, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X1X Burial 2 Cremation 3 Removal from State |Parkwood Cemetery 2~15~2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstrictive Polynonger Physician Y29115 Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death

Box 68760. P.O. Division or Vital Records,

burial-trans and physician at the burial that the death certificate be use as t for been signed by the should be detached has le 2 page certificate After this funeral or Attending within 24 hours after death.

To the Funeral Director: Aft

death with the Maryland

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inforcant: If them 27 Is marked other than "natural", or ite miprochant: If ithen 27 Is marked other than "natural", or any injury or other traumatic event, the Medical Examine

altimore, Maryland 21215-0036

Certification: To the Hospital

28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

ı	29a. Certifier
ı	(Check only
ı	one)
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 00061199 MA

29d. Date signed (Month, Day, Year) Feb, 11, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701 North Charles St, Suite 41051 Touson, MD 2 1204 SIGCKMD 6 32. Registrar Signa

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Joseph Kirk 2010 12:20 p M Pebruary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Patuxent River Health & Rehab Laurel Prince George's Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1XX M 2 🗆 Months Days Hours Min (Month, Day, Ye Country)
New Jersey Director 139-12-6189 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13201 Sandston Court 20708 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3XXWidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Nuclear Sergeant Major for Powerplant US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental Hittem 27 is marked ot ပ Peter Kirk Edith Wende 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Kirk/ Son 206C Faller Drive, New Milford, NJ 07646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date artment of H
ortant: If ite 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 13/16/2010 Arlington, VA 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses Der Der any MICH M01103 313 Talbott Avenue. Laurel, MD 23a. Part 1/ En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one crude on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ End Stage Renal Disease disease or condition month Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed page 2 should 24a, Was an 24b. Were autopsy findings available has prior to completion of cause of performed? certificate 1 Yes 2 X No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1

Matural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work? 1 ☐ Yes 2 ☐ No. 5 Pending injury 2 Accident
3 Suicide
4 Homicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number

Registrar

68760

Box

P.O.

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Syed Akbar Ali Sadiq,

FEB 1 6 2010

31. Date filed (Month, Day, Year,

D24721

14333 Laurel Bowie Road, Suite 208, Laurel, MD 20708

February 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Louis Krogman III 2010 10:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Health & Rehabiliation Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖔 F Months Country) Director 218-07-9417 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Linthicum 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 108 South Longcross Road 21090 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ⚠ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Architectural Elementary/Seconday (0-12) College (1-4 or 5+) Master Machinist Hardware Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Louis R. Krogman Jr. Alberta Tighe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Lois Krogman /Wife South Longcross Road Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 15, 2010 Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Services PA 1 2nd Ave. SW GLen Burnie, MD 21061 MOIIZI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ermen disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 L Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed r this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending work? 2 No Accident
Suicide Investigation Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ngton 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04:25A - EBRHARY <u>Kane,</u> Jr. 2010 Thomas <u>Joseph</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT JUSEPH MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Aug 21, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Yrs Washington DC 213-32-2324 75 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🛱 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Straffan Drive, unit 105 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Director Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Thomas Joseph Kane, Sr. Mary Turke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Straffan Drive, unit 105, Timonium, MD 21093 Rosa-Maria Kane/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mary's Cemetery 2/15/10 Baltimore, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Padonia Road, Timonium, 23a. Part 1. Enter th shock or heart disease, or complications that cause allure. List only one cause on each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final PRATORY ARREST or condition HOUR resulting in death) 5 DAYS LEFT HEMISPHERIC STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 5 DAYS ANEURYSM THORACIC Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year HYPERTENSION

Physician/ Medical Examine attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed

Physician/

Medical

Examiner

Funeral

Director

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Director

Funeral

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72 hours after death with the Maryland

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Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Examir Physician/Medical signed by the a Completed by funeral director, Certificate: To Be within 24 hours after death
To the Funeral Director: completed filled in by the f

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After this certificate

CHRONIC OBST	RUCTIVE PULMONARY DISEASE	
Part II. Other significant condit	tions contributing to death but not resulting in the underlying cause given in Part I.	2
9 Unknown	9 Unknown	

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No

25. Was case referred examiner? 1 Yes 2	.1
27. Manner of Death	
1 X Natural	5 Pending
2 Accident	Investig
3 Suicide	6 Could r
4 ☐ Homicide	determi

lospital	1 Inpatient 2	ER/Outpatient	3 🗆 1	DOA
28a	Date of injury (Month, Day, Year)	28b. Time of injury	М	28c.

(Chec	ck only one)
ing H	ome 5 Residence 6 Other (Specify)
	28d. Describe how injury occurred

on be	(Month, Day, Year)	injury M	work?	2 🗌 No	28d. Describe how injury occurred
d	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier	1 Certifying Physician: To the best of my knowledge, or	leath occured at the time, date and place, and du	e to the cause(s) and manner as stated.							
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
only one)										
29b. Signature a	ad title of certifier	29c. License number	29d, Date signed (Month, Day, Year)							

	Magne	Hullm	m.D.	
_		1 11 1 51 1		Ξ

Investigati 6 Could not

26. Place of Death Other:

4 🗌 Nurs

8,2010

TOWSON MARYLAND 21204

of person who completed cause of death (Item 23a) (Type, Print) m.D. REICHMAN 7601 OSLER DRIVE

31. Date filed (Month, Day, Year)

√ 32. Registrar's Signature

State Registrar

Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20/0 Month **Physician** HENRY KEEFER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sep. 24, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Year) 920 Days 1**√** M 2□ F Months Maryland 213-16-3931 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Anne Arundel 1 ☐ Yes 2 ☑ No Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30 Hampton Road 21090 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? VE Yes 2 □ No WWI If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 2□No WWII 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No White Specify. þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Refueler Aviation Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Keefer Marie Poteet ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Keefer - Wife 30 Hampton Road, Linthicum, MD 21090 20b. Place of Disposition (Name of MD Chief Place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD drownsville 2-5-2010 Crownsville, MD 4 □ Qonation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEVERE COR ONARY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit one poletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29c. License number 29b. Signature and title of certifier RES 000 DR. FRANK LEE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVER ALTIMORE, MD 21225 32. Registrar's Signature Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Betty Jane Kocher Feb 2010 7:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day Yer Harford County Lorien Nursing and Rehab Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1920 Sunbury, PA Days Hours Months 1 M 2 XF 189-09-9703 89 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or Items 23a or 28a-f shor Harford County Churchville 1 □Yes 2XXNo Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 131 Goucher Way 21028 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) marked other than College (1-4or 5+) Elementary/Secondary (0-12) Hutzler's 12 N/A Dept. Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev William Vought Margaret Gittings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Goucher Way, Churchville, Maryland 21028 Richard W. Kocher (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Evans Funeral Chapel Feb. 9,2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - BelAi
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service, Licensee Jehn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DEMENTIA **Physician** ENDSTAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): g physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ₩ No Day Month Year 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à ATRIAL FIBRILLATION, COPD 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? HYPOTHYRDID 24a. Was an has autopsy perform page The J certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 12 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of I or Attending P after death. 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 □Yes 2 □No within 24 hours after death. To the Funeral Director: A investigation the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar
DHMH 17 Rev 1/2001

am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

141)

Suresh Mulchand Dhanjani 622 South Union Ave. Havre

345344

02/08/2010

de Grace, MD 2107 ?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7,2010 Year **Physician** February 7:30 Dorothy M. Kalbskopf /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 3728 E. Joppa Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 31, 1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F Kentucky 75 414-50-3697 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Evanings must be notified at Baltimore Baltimore 1 ☐ Yes 2 No **Funeral Director** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23a or: USA 21236 3728 E. Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 TNo Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Proctor Gamble College (1-4or 5+) Elementary/Secondary (0-12) Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Opal Sisk ဂ George Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau 3728 E. Joppa Road-Baltimore, Maryland 21236 Joseph R.Kalbskopf-spouse 20b. Place of Disposition (Name of cemetery, organizary or of the place)

Evans Funeral Chapel

and Cremation. Belair 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility h ME todal endrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of) Examiner whan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Hnknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes To the Hosping.

Within 24 hours after death.

To the Funeral Director: After this certifics

To the funeral director, it is a funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the or ther: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 28a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Frank Woodward Keeney, Jr. 06 201Ö 6:55 P. Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Parkville Oak Crest Retirement Community 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign March 02, 1920 Baltimore, MD. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 D F 89 215-14-4940 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Baltimore County Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21234 United States 4408 Hampton Place within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Xes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates. W.W.II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Cinder & Concrete Elementary/Seconday (0-12) College (1-4 or 5+) Il Hygiene. President Block Corp. 12 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed th and Mental H 27 is marked of traumatic ever Rose Long Frank Woodward Keeney, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health of Item 27 is other tra Freeland, MD. 21053 Mrs. Karole K. McElwee(Daughter) 20409 Keeney Mill Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State Feb.13, 2010 = 5 Department of Important: If any injury or once. Dulaney Valley Mem. Garden's 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Micenset Jeffrey L. Cair, Sr. Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 York Road Timonium, Maryland , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Parl 1. Enter the disease, or co shock, or hear trilure. List only Interval Between Immediate Cause (Final Onset and Death Hortic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? i filled in by the funeral director, page 2 should be det þ Hospital or Attending Physician: The law requires CHF, HIN 1 ☐ Yes P ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2

To the

Frank

HX

32. Registrar's Signature

G. Harrison CRNP

- GMMN person who completed cause of death (Item 23a) (Type, Print)

(Check

only one

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8800 Walther Blud, Parkville, MO 21234

29d. Date signed (Month, Day, Year)

2/8/2010

29c. License number

R171944

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# 20b perFH. G900.2 16/2010 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Season's Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Months 1 □ M 💥 □ F 247-58-8941 Yrs 06 Director 79 05 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show MD NA Baltimore 1XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 2121 Windsor Garden Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: Black 3 ☐ Widowed 4 🏿 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proctor & Gamble Machinist llth grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Mumford Elizabeth Mumford မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3596 Fels Lane, Ellicott City Md 21043 Joseph King-Son permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 4 Donation 5 ☐ Other (Specify) 2/15/10 Woodlawn, Md 21. Signature of Funeral Service License March FyH West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final disease or condition resulting in death) **Physician** BREAST /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or mjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 1∐Yes 🎢 🕻 No of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 5 \sum Residence 1 Yes SENo Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Division 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: # 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

For Amend #7 per Fn 6900 2/17/10 TT Indentitie ink. Ensure All Copies Are Por State Registrar Amend # 8 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No./ 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Kinasborouan 1415 **Physician** 8 2010 lames uaru /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Days **Funeral** 247-30-142 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural?" -- " any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black 1 ☐ Never Married 2 ⚠ Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Se copdary (0-12) Be ဂ္ 20b. Place of Disposition (Nam cemetery, crematory or of ed of Disposition Burial 2 Cremation 3 Removal from State Other (Specify) 21. 3 gnature of Funeral Se 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute tailing **Physician** /Medical Due to (or as a consequence of) Examiner habdomyolybis Sequentially list o in its ins Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) cancer or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 🗍 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\sqrt{N}\) 2 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 2 PR/Outpatient 3 DOA 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this 28d. Describe how injury occurred 27. Mangler of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Res -000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Cyrus Shahpar MD 32. Registrar's Signature 31. Date filed (Month Day, Year) State 16 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Physician/ KASTINA FEBRUARY 08:25 PM WALTER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BAUTIMORF 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F Hours Min. Maryland 220-09-839 Director 90 January 14,1920 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Baltimore Dundalk 1 Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7504 Durwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 XYes 2 If Yes, Give Black, White, etc 1 Never Married 2 XMarried þ 2 No 1 ☐ Yes 2 XNo Specify: White 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicaal. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 years Iron Worker Glazier Local 16 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Kastina Sophie Fologin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 Mardic Drive, Forest Hill, Maryland 21050 Ronald Walter Kastina son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February XBurial 2 Cremation 3 Removal from State Sacred Heart of Mary Cem. 4 Donation 5 Other (Specify) 17, 2010 Dundalk, Maryland Signature of Funeral Service Licensee Conneily Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. onto enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEMOPNEUMOTHORAX disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1 WEEK Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 No ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated by page 2 should be 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director and the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760 P.O. | Records, Division of Vital

Maryland 21215-0036

Baltimore.

DV

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4940 EASTERN AVENUE BALTIMORE, JENNIFER CHEN

31. Date filed (Month, Day, Year) FEB 1 6 2010

Registrar

RES-000

FEBRUARY 12, 2010

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1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Geri Holly / Da	ughter		2301	Seminary	Road, Si	lver Sp	ring.	Mary1	and 20910		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen:		M0136	$\begin{bmatrix} 1 \\ 1 \end{bmatrix}$	2 Name and Addre Kobert A. Pi 7557 Wiscons	imphrey Fur	neral Home	/Bethe	sda-Chev	y Chase, Inc.		
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Physician/		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line		mor	0.00					Interval Between Onset and Death		
Medical		disease or condition resulting in death)	a. Due to (or a a										
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FFMALF:											
ith cer ttendi or use	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🔲 Fetal	death 3	Ectopic pregnanc	≽y .		2	3d. Date of deli Month	very Day Year		
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To the vithin To the somple	Σ	only one) 3 L Certifying Nur-	se Practioner: To the t	best of my	knowleage,	29c. License				signed (Month)			
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(ta)		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print)							
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02/15/ PATRICIA BELL KISNER 3:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Care Towson Baltimore 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Months Days Hours Director 80 <u> 215-26-6680</u> Marvland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗹 No MD Anne Arundel Pasadena 10e. Street and Numbe 10g. Citizen of What Country? Funeral 171 Dale Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 1 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Administration permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. McCrobie Helen E. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Kisner / Son 171 Dale Road, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory | 02/16/10 Baltimore, MD Signature of Funeral Pervice Licensee 22. Name and Address of Facility G.J. Gonce Funeral Home, <u>Riviera Drive, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Stag Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate near First Uncertainty Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death as been signed by the 2 should be detached g 🔲 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has page, 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After
mpleted filled in by the funer 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Filboury R149194 15,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant 201 Towson N. Charles MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. C U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Nata KerchBaum 1371 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Latique Cau clumbia Howard If Under 24 Hrs. 8. Date of Birth Hours Min. 12/01/1914 If Under 1 Year 5. Social Security Number 37/6 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2**V**□ F Months Days 95 Director PA Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating to pulling at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD HOWARD COLUMBIA Director 1 ☐ Yes 2/CYNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6164 DEVON DRIVE 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Completed by WHITE Specify. 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J0SEPH BRENNER 2 SARA KATZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other traum once. CAROL KERSHBAUM/DAUGHTFR 3 RED OAK DRIVE, ELKINS PARK, PA 19027 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State ROOSEVELT MEM. PARK 02/14/2010 TREVOSE, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 3 days reumonic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (U or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): burial-tran attending physician and Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 □ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Monpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury s after oe. ral Director: Att 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb 13 Th 2016 12008019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tomader Miva MD 4710 Pennington Au-Balt-MD 21226 31. Date filed (Month, Day, Year) State

Registrar

FEB 16-2010

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384	Physicia Medic		JOYCE N		Last) MELMAN	2. Date of Death FEBRUARY						201 ^{Year}	3. Time of Death 11:38 A M
=	Examiner 4a. Facility Name (if not institution, give street and number) NORTHWEST HOSPITAL								Location of Death	4c. County of Death BALTIMORE			
2010	Funeral Director		539-18-88 317-43-66	52 79	6. Sex 1 □ M 2 XX F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 1 <i>y, Year)</i> 1927		nplace (State or Foreign ntry) WA
-	land show dat.	or	Usual Residence of D 10a. State	Decedent 10b. County			y, Town or Lo	cation		1101 201			10d. Inside City Limits
5	e Maryla r 28a-f notified	Direct	MD 10e, Street and Numl		IMORE		ВА	LTIMORE					1 🗆 Yes 2 XX No
Mar	with th s 23a o	Funeral Director	1308 ST.		S ROAD			2120	8		-	ten of What Cou USA	untry?
February	Ind 21215-0036 If filed within 72 hours after death with the Manyland tal Hygiene. So other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4	ed 2 🏿 Marrie	12. Was Deceden	?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 💢 No		ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify:	
AV	:15-0 72 hou In "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)				(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ring	16b. Kin	nd of Business I	ndustry
X	212 d within dygiene. lyer tha	Be Co	Elementary/Secon		College (1-4 o	r 5+)	НОМ	EMAKER				HOME	
加	land the file fental H riked of tic ever	일	17. Father's Name (Fi	irst, Middle, La	TAYLOR				18. Mother's Nam RUTH	ne (First, Middle,		urname) GETTE	
KIMMECMAN	Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of any Injury or other traumatic event, the Medical Exami once.		19a. Informant's Nan DAVID KIM				1	ng Address (Street a			-	own, State, Zip	
Z	Baltimore, permit. Page 1 and 3 Department of Healt Important: If item 2 any Injury or other once.		20a. Method of Dispo 1 ☑ Burial 2 ☐	osition Cremation	3 ☐ Removal from Sta	te c	Place of Dispo emetery, crea	osition (Name of matory or other place	ce)	Date	20c. Loc	cation - City or T	Town, State
ayce	Baltin permit. Pa Departme Importan any Injury		4 Donation 21. Signature of Fund			реп		EMORIAL P				BROS.,	
13			23a. Part 1. Enter th	e disease, or d	complications that caus	ed the deat	18	<u>900 REIST</u>	ERSTOWN I	ROAD	<u>PIKFS</u>		MD 21208 Approximate
	Physician/		Immediate Cause (Final disease or condition a Acute Myocandial intarction a Acute Myocandial intarction									Interval Between Onset and Death	
1	Medical Examiner		Due to (or as a construence of): Sequentially list conditions, b. Chronic Obstructive Pulmonary Disase										
	rted J ansit	Examiner	if any, leading to imr cause. Enter Underly Cause (Disease or iii	mediate ying njury	Due to (or a	s a consequ	uence of):		9114 (16-x 17.95)	-			
7	be executed sician and burial-transit	cal Ex	that initiated events resulting in death) La		Due to (or a	s a consequ	uence of):						
	8760 tificate l ng phys as the	Medic	IF FEMALE:	123	d								
	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the b.	Physician/Medical	23b. Was decedent p in the past 12 m 1 Yes 2 Y 9 Unknown	onths?	23c. If yes, outcon 1 Live Birtl 4 Pregnan 9 Unknow	n 2 ☐ Feta tat time of o	al death 3	Ectopic pregnanc Other (specify)	ру		23	3d. Date of deli	very Day Year
	rds, P.O equires that t een signed b rould be deta	Completed by P	Part II. Other signific	tem	ns contributing to death	but not res	sulting in the u	underlying cause giv	ven in Part I.			No 3 ☐ Pro	the cause of death?
	Reco	Compl				. , ,				24a. Was auto perfo	psy ormed?	24b. Were auto prior to c death? 1 \square Yes	opsy findings available ompletion of cause of
	/ital sician: certific lirector,	To Be (25. Was case referred examiner? 1 X Yes 2		Hospital:	ationt 2 🗆	EP/Outpatie	26. PI	ace of Death (Chec	k o <i>nly</i> o <i>n</i> e)	dance of	Other (Specif	£.1
;	of Of Oding Phy Ith.		27. Manner of Death 1 Natural 2 Accident	5 Pending	28a. Date of in (Month, I	ijury Day, Year)	28b. Time or injury	28c. Injun work	y at	28d. Describe			
	ivision of the state of a street of the color of the colo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determin	ot be 28e. Place of	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location (S City or Tov	vn, State)	136650	al Route Number, NAI Zan & d
'	E Hospita 124 hours e Funeral	Medical		Medical Ex	Physician: To the best saminer: On the basis o Nurse Practioner: To the	of my know f examination	ledge, death n and/or inves	tigation, in my opinio	on, death occurred a	nd due to the ca	and place, a	I manner as stat and due to the c	ted. ause(s) and manner stated.
	To th withii To th comp		29b Signature and ti		d Fer	2 4		29c. License				signed (Month,	
	4		30. Name and address	ss of person w	ho completed cause of	death (Item	23a) (Type, I	Print)	11.1100	- 1. H	- C - C - C - C - C - C - C - C - C - C	1100	12,0010
	Sta Registra		31. Date filed (Month)	Day, Year)		trar's Signa	So An	KIMPLE	17,010	-414	WIV.	114,00	4 21043
	negisti	- 1		DIG	THE PORT	~ /	-7	17.04(1)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 6 KREVOLIN 2010 12:00P ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1486 GREENBRIAR CIRCLE BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) PA **Funeral** 1 X M 2 □ F 1072771950 Director 172-42-5241 59 Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 1486 GREENBRIAR CIRCLE USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4_or 5+) COMPUTER TECHNICIAN FINANCIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be MEDWIN HARRY KREVOLIN SELMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HYLL KREVOLIN / WIFE 1486 GREENBRIAR CIRCLE, BALTIMORE, MD 21208 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 5 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State injury 4 Donation 5 Other (Specify) MEADOW RIDGE CEMETERY 02/09/2010 | ELKRIDGE, MD 21. Signature of Juneral Service Licepe 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No ed by the a g Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed or Attending Physician: The 2 🗆 No 1 Yes 25. Was case referred to medica **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မြ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 701 N.C 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE AT NORTHWEST HOSP. BALTIMORE RANDALLSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9/2/1925 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ X Days BELARUS 217-37-4093 84 Director Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □ No Director MD BALTIMORE REISTERSTOWN 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 12020 REISTERSTOWN ROAD 21136 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No or items 11. Marital Status 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No 2 If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced "natural", WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be GELFAND RIVA MATZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANATOLY KOZLOV/SON 456 DOE MEADOW DRIVE, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CEMETERY 2/12/2010 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 21. Signature of Funeral Service. SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of and burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical the IF FEMALE: yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No cate has by page 2 sl 24a. Was an autonsy performed? certificate | Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** <u>9:</u>08^{a-м} /Medical **FEBRUARY** KENT 2, 2010 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY Year | If Under 2 PRINCE GEORGE'S 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Davs Hours 578-70-1690 Director 29, Feb. 1952 N.C. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be notified at Director M∑Yes 2 No Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1615 Tulip Avenue 20747 Funeral United States Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify: 3 ☐ Widowed 4 X Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) af Hygiene. I other than " Elementary/Secondary (0-12) 12th College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 Ia marked of any injury or other traumatic ever Unknown Rosa Davenport 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franz Kent / Son 7936 Moose Ave. Norfolk, VA 23518 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 2-15-2010 Washington, D.C. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 23a. Pert 1. Enter the disease, or shock, or heart failure. List complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician ATHEROSCLEROTIC HEART DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Directo (or as a consequence of) lor Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical Box (IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 2 HYPERTENSION, SARCOIDOSIS, OBSTRUCTIVE SLEEP APNEA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ CUnknown Be Completed ARTHRITIS 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Vital 1 ☐ Yes 2 💽 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ð 1 🖳 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a 1 Size Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) V Japle Souto

State Registrar 31. Date filed (Month, Day, Year) - ---32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doris V. Pablo-Bustos, M.D.

FEB 1 6 2010 Sewa S. face

3001 Hospital Drive

D0058776

Cheverly, Md.

Feb. 5, 2010

20785

10-01342 Jeffrey Keifer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

effrey Keifer		State of Maryland / Department of Certificate of Ce	of Health ar			2010	03713
Physicia ledical Examin	n/	Registrar 1. Decedent's Name (First, Middle,Last)	-		Reg. 2. Date of Death Month D February 14		3. Time of Death 0805 hrs
d		4a. Facility Name (if not institution, give street and number) 6 William Court	4b. City, Town, o	or Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 M 2 F 56 Yr	If Under 1 Ye Months Da		8. Date of Birth(April 2	MM/DD/YYYY) 9. Bir 2, 1953 Foreig Co	thplace (State or on ^{ountry)} Mary land
Aaryland 28a-f show any Latonce.	tor	Usual Residence of Decedent 10a. State	ation 10f. Zip Code		100.	Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
vith the Mar s 23a or 28 c notified a	ral Director	6 William Court	21152	lispanic Origin? (S		USA	ican Indian, Black,
٠ . ٠ ا	by Funeral	1 Never Married 2 Married Armed Forces? If 1 Yes 2 No If Yes, Sive Year or Dates:	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	White, etc.	hite
5-0036 led within 72 hour Hygiene. Tygiene than "natu the Medical Exau	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ during r A S S O		e. DO NOT use reti rector	red)	Univ. of	
215-0036 be filed within 7 intal Hygiene. irked other than vent, the Medica	B B	17. Father's Name (First, Middle, Last) John Gilbert Kiefer		Georgia		gest	
y, MD 2121 and 2 should be fi fealth and Mental I fean 27 is marked fean 27 is marked	۵[Judith R. Kiefer / Wife 6 Wi	lliam Co	urt Spar	ks, Mary	er, City or Town, State 1and 21152	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatit event, the Medical		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition or crematory or of Hilltop	other place) Serv. Co	rp. 3/2	2/2010	Towson, Ma	ryland
	-	21. Signature of Funeral Service Licensee 22. R 23a. Part I. Enter the disease, or complications that caused the death. Do not enter				ry an Inc. 1050	York Road Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Atherosclerotic card</u>				, SHOCK, OF HEAR	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b					
	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
execui an and al - tra	dical Ex	d. W. AMENDED			001 0/10	./10 ===	
	왉	#I as noted, IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3			23d. Date of delivery	/ Day Year
Box he death of the attenty the attenthed for us	Physic	1 Yes 2 No 9 Unknown 9 Unknown 5 C Part II. Other significant conditions contributing to death but not resulting in the	other (Specify)	given in Port I	23e Did toba	cco use contribute to	the cause of death?
S, P.O	2	Part in Other Significant Conditions Contributing to death but not resulting in the		given in rait i.		2 No 3 Prob	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should tal	Completed				autopsy performe	prior to death?	completion of cause of
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f Vi Physi er this	의	1 ✓ Yes 2 No		ury at Work?	g Home 5 Re	sidence 6 🗸 Other	Scene
OD O ending sath. or: Aft	tion:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation		Yes 2 No			
Divisal or At urs after d	Certification	3 Suicide 6 Could not be determined (Specify)	et, factory, office	building, etc.	28f. Location (Street or Town, State		ral Route Number, City
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	urred at the time, o ation, in my opinic	date and place, and on, death occurred a	due to the cause(s at the time, date and	s) and manner as state d place, and due to th	ed. e cause(s)
7 ≥ 5 8	Me	29b. Signature and title of certifier 3 July 2 and manner stated.		se number		9d. Date signed (Moleculary 15, 201	
AV		Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	Penn Street,	Baltimore, M D	21201		
Sta	ate	31. Date filed (Month, Feb. (e.r.) 32. Redistrar's Signature	bard 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Johnnie Lacey, Jr 11:45a M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death 2115 Cliftwood Avenue Baltimore na 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birtholace (State or Foreign Funeral Days Hours Min. 1 XM 2 - F Director 62 218-46-8967 MD Usual Residence of Decedent 28a-f show 10a. State 10h County 10c City Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 □ No Baltimore na MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2115 Cliftwood Avenue items 23a Funeral 21213 U S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes ZNO
If Yes, Give
Year or Dates. Black, White, etc 0 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Black "natural", Specify: 3
Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Machine Operator grade Ammoco Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johnnie Hampton Lacey, Sr Vivian Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mary Lacey-Wife 2115 Cliftwood Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 2-16-2010 Balto, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ^{of Facility} March East F/H North Avenue Balt 1101 E. MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ infarction myocardia disease or condition acreti Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending properties of IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pulmonary hypertension Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No page 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** funeral director, Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred I or Attending F after death. injury Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D0040208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) June Breiner york Rd Sty 32C Lutherville MD 1205 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ Date of Death Month Decedent's Name (First, Middle, Last) 8 40PM **Physician** 0 04 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 946 ROSEDALE AVENUE ROSEDALE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Days Months Hours 1 ☐ M 2 🔯 F 81 217-24-2163 3-23-1928 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the McCital Experiment must be notified at MD BALTIMORE ROSEDALE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 946 ROSEDALE AVENUE 21237 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give 2 Specify WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene.

is marked other than College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I ANDREW F. PANUSKA MARY (KUDRNA) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 and 2 bepartment of Health a Important: If item 27 is any injury or other trau THERESA BURES/DAUGHTER 1013 ROSEDALE AVENUE ROSEDALE, MD 21237 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GARDENS OF FAITH 2-9-2010 BALTIMORE, MARYLAND 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 00 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine RONA burial-transit 0 and Due to (or as a consequence of) Box 68760. attending physician pe Physician/Medical the as IF FEMALE for use yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day yes P No 9 □ Unknown 5 ☐ Other (specify) ned by the a detached f Ö ۵. s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I of Vital Records, 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No 24a Was an has page this certificate 1 ☐ Yes 2 Ø No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hesidence 6 Other (Specify) Hospital: 1 Yes 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Division Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendii ours after death. neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Hospital 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fil (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier aw leted cause of death (Item 23a) (Type, Print) 30 Name and address of person who comp ARNI. ND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 16 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Lana Sue LaSeta February 10, 2010 5:48 pm Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ohio 8. Date of Birth Funeral 1 🗆 M 2 🗶 F Months Days Hours Min $\mathbf{Oc}^{(Month,3)}$ 280-42-8677 65 1944 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Maryland Phoenix 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13403 Jarrettsville Pike 21131 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No <u>م</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Norwood Rinehart Idabelle Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13403 Jarrettsville Pike Phoenix, Maryland 21131 Frank LaSeta, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 610¹², Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ BMast disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month 1 Yes 2 9 Unknow tate has been signed by the spage 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 2 🗌 No Yes 2 1 Yes **Physician**: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUKS MM MON filed (Month, Day, State

Registrar

Box 68760

P.O.

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEB. DOROTHY L. LOMBARDI 2010 9:25P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 1882 Emily Drive Edgewood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Dec. 12, . Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 💥 🕽 F 214-14-5417 87 Maryland Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Edgewood Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21040 1882 Emily Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married Yes XX No 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White 3x Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Restaurant Industry Manager 11th grade Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances L. Hirsch George C. Lein per it. Page 1 and 2 should ce Derartment of Health and Men Important: If item 27 is marke any injury or other traumatis one. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1882 Emily Drive Edgewood, Md. 21040 Darlene Early (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory, Inc. 2~9~2010 Baltimore, Md. 21236 LASSAHN FUNERAL HOME 7401 Belair Rd. Baltimore, re of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 40 card massive disease or condition Medical resulting in death) Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s performed? Yes 2.2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No *Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours are
To the Funeral Dir Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Baltimore, MD 21236 32. Registrar's Signature State Registrar

OM BAR

eRothy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		partment of learning partment			giene Reg. No 201	0 03718
	, _,		Decedent's Name (First, Middle,	Last)			_	2. Date of Dea	ath	3. Time of Death
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ر	Exami	ner	4a. Facility Name (If not institution, The Johns Hopkins			Baltimore	or Location of Dea	ıtn	4c. County of D	1 A
	Funeral		5. Social Security Number		e (In yrs. last birthd	y) If Under 1 Year		(Month, Day	h 9.	Birthplace (State or Foreign Country)
0.00	Director		217-62-1010 Usual Residence of Decedent	MASVI Z L F	45 Yrs			2/21/1	1964	MD
	aryland show	Ŀ	10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	the Ma 28a-f otified	Director	MD Worce	ster	0cear	City 10f. Zip-Code			10- 04	1 Yes 2 X No
	death with the Mary ems 23a or 28a-f sh r must be notified a	al Di	14003 Loop Rd	1 -		218	42		10g. Citizen of What	•
	r deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	Was Decedent of I If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)		merican Indian,
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notifled at	þ	1 Never Married 2 XMarrie	d 1 Tes 25.51 If Yes, Give Year or Dates:	40	1 ☐ Yes 2XXXNo	Specify:		Specify:	White
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nd 2	be filed within 72 hours after dea ital Hygiene. ed other than "natural", or items event, the Medical Examiner mu	Be C	17. Father's Name (First, Middle, La	ist)		,aregree	18. Mother's N	ame (First, Middle,		Joyeu
Maryland		P	Eugene M. Luc		40. 14			ret Hager		
Ma	s 1 and 2 should f Health and Me item 27 is mark other traumatic		19a. Informant's Name/Relationshi Erika Lucas/W			ailing Address (Street				э, Zip Code)
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Baltimore,	t. Page tment tant: If tant: o		4 Donation 5 Other (Spe	ecify)	1	oll Crema	tory 2/	17/2010	Winfield	
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Juneral Service Lice	B Call		Burrier	Queen Facility Fu	neral Hom	ne & Crema	ntory, P.A. MD 21784
			23a. Part . Ent it the disease, or conship ck, or leart failure. List on	omplications that caused live one cause on each line	the death. Do not	enter the mode of dyi	ng, such as cardi	ac or respiratory an	rest,	Approximate Interval Between
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	/Medical Examiner		resultin Allo eatri)	Due to (or as a	consequence of):	1 1				
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8760,	ificate be executed g physician and as the burial-transit	edical		d						
	rtificate ng phy e as th	Med	IF FEMALE:							
Box	v requires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at t	2 🗌 Fetal death	3 Ectopic pregnanc 5 Other (specify) _	ey .		23d. Date of Month	delivery Day Year
		hysi	1 □ Yes 2 चि∕्रिश् 9 □ Unknown	9 Unknown						
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Division of Vital Records,	v requi	Completed						24a. Was ar		autopsy findings available
Re	The law ute has t	omo					· · · · · · · · · · · · · · · · · · ·	autops perforr 1 Yes	sy prior	to completion of cause of
Vita		Be	25. Was case referred to medical examiner?	Hoonital:	/	l Out		ath (Check only one		
o d	Physiclan: this certifica aral director,	5	1 ☐ Yes 2 ☑ No 27. Mann of Death	Hospital: 1 Thipatien 28a. Date of Injury	t 2 ER/Outpat		4 L Nursing F		ence 6 Other (Sport of Course)	pecify)
sion	or Attending after death. Director: After in by the fune	Certification:	1 atural 5 Pending investigat		Year) Inju	y Wor	ć? Yes 2 ∐ No		,,	
Six!	or Atten after deat Director: I in by the	rtific	3 Suicide 6 Could no determine			street, factory, office		28f. Location (Si City or Town		Rural Route Number,
_	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After this completely filled in by the funeral	a Ce	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occurred at the tir	me, date and plac	e, and due to the c	ause(s) and manner	as stated.
	the Hospital hin 24 hours the Funeral mpletely filled	ledical	310)	caminer: On the basis of condition and manner state	examination and/or ed.	investigation, in my o	opinion, death occ	curred at the time, o	date and place, and	due to the cause(s)
_	vithin To the comple	Σ	29b. Signature and title of certifier	Jaili MD	•	29c. Licens		2	9d. Date signed (Mo	nth, Day, Year)
		-	30. Name and address of person wi		eath (Item 23a) (Tvo		5-000	/	-ev. 17,	1010
			Rakhi Nai	W .			600	North Wol	fe St, Baltin	nore, MD, 21287
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. jegistrar	s Signature	0				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2340 Phylary Medical 4a Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death notion Social Security Numbe 6. Sex 1 ፟ M 2 ☐ F If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 205-12-9751 Months Days Hours Min. Dec. 18, 1915 94 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland 10d. Inside City Limits Director 1 Yes 2XXNo Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 677 Wellerburn Avenue 21146 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Trainer Security Services Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank B. Leisenring Maude Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Jane Burress/Daughter Wellerburn Avenue Severna Park MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9, 2010 Glen Burnie, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Singleton Funeral & Cremation ice Licenses Services PA 1 2nd Ave. GLen Burnie, MD 21061 Meizze 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a corr equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physiclan Physician/Medical Box 68760 SB IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Dav Yea 5 Other (specify) 2 No g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 🗌 No 1 Ves funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **X** No Hospital: Other: 욘 1 🗌 Yes After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. I Director; Aft 1 Yes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1.4

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 3. Time of Death Mary Jean Littman **Physician** 2010 19:20 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. Counfy of Death 4b. City, Town, or Location of Death **Examiner** Harford County Upper Chesapeak Medical Center Bel Air 8. Date of Birth (Month, Day,)
Feb. 14, 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 023-36-4726 1 □ M 2 🛛 F Days Hours Director 63 1946 Massachusetts Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Harford County Forest Hill Director Maryland 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2919 Ady Road 21050 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Lafarge N.A. 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Mental Lillian Montcalm John Edge ೭ and Nisma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Littman (Husband) 2919 Ady Road, Forest Hill, Maryland 21050 injury or other Baltímoré. Date 2010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ⊈Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 15, Evergreen Cemetery Feb. South Hadley, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - BelAir 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** armor arre /Medical Due o (or as a conse uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a cons vence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pay 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 2 No Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an re VIDUS 1 Yes 25. Was case referred to medical examiner?

12 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Hospital or Attending Pl 24 hours after death. Funeral Director; After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Tuly 5. 2007 | unknow M | 1 | 28e | lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident investigation Automobile acciden 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide City or Town, State)

Certifying Physician: To the best of my kn Medge, deat occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 hours a Funeral L 29a, Certifier Medical (Check only withir 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Dean Charles Ledford Feb 2010 2:00 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll 4154 Middleburg Rd. Union Bridge Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Months Days Hours 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Min. Days 64 Yrs 220-42-9702 Baltimore, Mp 12 - 1 - 1945Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Union Bridge Carroll 1 ☐ Yes 2 ☐ No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21791 USA 4154 Middleburg Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ∐Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Landscape Elementary/Secondary (0-12) College (1-4or 5+) Landscaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemary A. Jordan Dean Foy Ledford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosemary Wiesner-mother 4154 Middleburg Rd., Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-23-2010 Garrison, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee Chlen 254 E. Main St., Westminster, MD 21157 homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HERATIC Cracyons Due to (or as a consequence of): 30 urs 410000115m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Meas Lts 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 🗹 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medical

Completed by

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Certification: To

Medical

Physician

/Medical

Director

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ext. in et must be notified at once.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

The law requires that the death certificate be executed and burial-tran the attending pl detached signed be deta icate has been si , page 2 should b certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica stely filled in by the funeral director, p e Funeral I pletely the within 7

> State Registrar

2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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2-91-10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

Frederick St. TATE 76 W.D.

21787 TANEYTOUN

31. Date filed

3. Registrar's Signature

Va

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year YNCH 02:00 AM Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner baltimor Mary Lond luver CLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, 5. Social Security Number_ 7. Age (In vrs. last birthday Funeral Min. Months Days Hours 53 December 28,1956 Maryland 215-66-6615 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer in ust be notified at 1 ☐ Yes 2 No Director Millsboro Delaware Sussex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19966 USA 36782 Millsboro Highway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify. Specify: 5 3 ☐ Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Trucking Company 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Von Garlen James R. Lynch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36782 Millsboro Highway, Millsboro, DE. 19966 Joyce Derka Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 10, 2010 ^{22, Name and Address of Facility} Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. ture of Funeral Service Licensee 21. Sign Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Porto. **Physician** /Medical Due to (or as a consequence of): Cirrhoris Examiner Compensate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran and ue to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 월 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 1 ☐ Yes 2 No 2 👿 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the ft **∠** □ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of sertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGUE 51 BALA 22 South MIKLOSH 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:45 P M February 11, Erin M. Lyons 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Chevy Chase
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min Montgomery 5317 Kenwood Avenue 8. Date of Birth (Month, Day, Year) January 29, 1942 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days Hours Months 1 □ M 2 🖾 F 68 Ohio 300-38-7722 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Modical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 5317 Kenwood Avenue United States by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Tour Guide Tourism 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catharine McDonough George C. Malley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5317 Kenwood Avenue, Chevy Chase, Maryland 20815 Richard D. Mathias/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Carmel Catholic
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition February 19 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Parkersburg, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenu Bethesda, Maryland 20814 21. Signature of Funeral Service License 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 1 6 2010

Dennis A. Cullen, M.D. 7625 Wisconsin Avenue, Bethesda, Maryland 20814 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D40216

29d. Date signed (Month, Day, Year)

February 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 February 1358 P^{M} Liu Tan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
September 24, 2008 Washington, D.C. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral 1 X M 2 D F Months Days Hours Director 214-83-8452 Usual Residence of Decedent shov 10a. State 10c. City. Town or Location the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number Funeral items 23a 20854 United States 10310 Great Arbor Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 6 1 X Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Asian "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 0 None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event Xiaoying Shan Jing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10310 Great Arbor Drive, Potomac, Maryland 20854 Xiaoying Shan / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12, 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Sepsis Medical resulting in death) **Examiner** Severe Bronchopulmonary Dysplasia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed Extreme Prematurity and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 🗌 Ectopic pregnancy for in the past 12 months? Year Month 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ spital or Attending Physician: The law requires to ours after death.

leral Director: After this certificate has been sign filled in by the funeral director, page 2 should be 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 24 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) e e examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No မြ 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 24 hours Medical **XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 1+ 2010 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20b per In, g900, 02/16/2010dnb r Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6.05 AM JANUARY 2010 1USSIE ond 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 21229 Baltimore Baltimore, Baltimore, maniformed.

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Months Days Hours | Min. 8. (Month, Day) vindton Lr Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year! Days Hours 1 ☐ M 2 X F Yrs 219-22-022 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examiner must be retitled at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Anne Arundel Severna Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8023 Old Mill Court U.S.A. Funeral 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public School **Janitor** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Long Mary Long ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8023 Old Mill Court Severna, Maryland 21144 Cravin Sewell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 02/12/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -02/06/10 Hanover, Maryland St. Rest Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 2121

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMINIA **Physician** EW DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): デルSs バュームップ ら Division of Vital Records, P.O. Box 68760 physician Physician/Medical the as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 12 No the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ RENAL FAILURE 2. No ANEMIA 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 X No 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**⊠**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Characteristic Description (and place) and manner as stated.

Characteristic Description (and place) and due to the cause(s) and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert 30,2010 MO Doi 62634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWAN 10802 HICKORY RIDGE 2/044 TEEN 10 COLUMBIA MO

Registrar

State

32. Registrar's Sigesture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ODESSA LEE 11:26 PM FEBRUARY 201D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M 2 🔀 F Hours Director Jul 31, 1931 217-24-7016 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Baltimore Maryland **Baltimore** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 700 Eastshire Drive 21228 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married <u>م</u> 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ John Johnson Laura Johnson . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark jury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Eastshire Drive Baltimore, Maryland 21228 Deborah Lee 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 02/09/10 Laurel, Maryland Maryland National Park Cemetery 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1306 Eutaw Place Baltimore, Md 2121 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CHRONIC PULMONARY OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death g Unknown ţhe ☐ Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) ë 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t work? 1 X Natural 5 Pending Certifical 2 🗆 No Accident Investigation 6 Could not be completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier I 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 24 within 2 To the 1 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD FEBRUARY 1, 2010 ss of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern AVE BALTIMORE MD 21224

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 00:22 M Robert Weidner Matthews, 2010 Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth
(Month, Day, Year)
Dec. 10, 1947 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F Months Hours Min. Dec. Director 62 375-52-4438 Ohio Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Prince George's Adelphi 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7301 17th Ave. 20783 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 1971-72 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Page 1 and 2 should be filed within Thent of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Software Engineer Defense Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Weidner Matthews. Sr. Trene Joyce Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Matthews / Wife 7301 17th Ave., Adelphi, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 2/12/2010 Beltsville, MD 21. Signature of Fyneral Service Licen ²² Name and Address of Facility Rapp runeral and Cremation Services 933 Gist Ave., Silver Spring, MD Rapp Futteral and Cremation 933 Gist Ave., Silver Sprin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final TERMIATION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ESUSCITA NON ONO NOSE **Director:** After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 \nearrow Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) exammer? Hospital: Other: 은 2 | No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature 29d. Date signed (Month, Day, Year) MI

State Registr<u>a</u>r 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

SKI MD

ess of person who completed cause of death (Item 23a) (Type, Print)

1400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month E13 MAYFIELD **Physician** YLUIA A 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lenah 13altimore Nursim If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 213-84-0277 46 02-22-1963 Maryland Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland leatth and Mental Hygiene. 10c. City. Town or Location 10a. State 10h County ral", or items 23a or 28a-f show Examinar must be notified at 1 NYes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2306 Winchester 21216 U.S.A. Funeral Street Apt.M 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. If Yes, Give 7 Year or Dates: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Black "natural" tal Hygiene. d other than "natura event, Ire Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Assistant Public Schools 2years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mayfield McCall 2 Woodrow Evelyn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3341 Winterbourne Rd Apt.B2, Balto., MD 21216 Tekeya Mayfield(Daughter) 20b. Place of Disposition (Name of Joseph Brown Place) H And Crematory 20c. Location - City or Town, State 20a Method of Disposition Department of important; if it any injury or o ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/13/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Joseph H. Brown Jr. Funeral Home 21. Signature of Funeral Service Licensee eliano 2140 N. Fulton Ave., Baltimore, MD 21217 Luc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired MMUNE DEFECIELY **Physician** disease or condition resulting in death) ्/Medical Due to (or as a consequence of): Disas ∕Examiner issemino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed Walnutation ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Tyes 2 TNo s been signed by the should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Ves 2 2 No cate has page 2 s certificate 1 □ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendliours after death.
neral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15503 Amolon NI Lacem

State Registrar

31. Date filed (Month, Day, Year)

32. Projetrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NNACEM

501 DOLDHIMST BALTO, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) West irginia Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 XM 2 □ F 220-53-1382 May Director 56 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a. State Director Maryland Baltimore Catonsville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 20 Briarwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14, Race - American Indian Black White etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 16b. Kind of Business Industry **Heating and** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Air Conditioning **HVAC Mechanic** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James Burnette Catherine McGrady 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Briarwood Rd Catonsville, Maryland 21228 Roger McGrady, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 12 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State Baltimore, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service License 22. Name and Address of Facility Cremation Society of Maryland, Inc. Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) within 24 hours arer death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Certificate: To Be Roge examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Alatural 5 Pending Investigation Accident 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the causety and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0064267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible lnk, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February William F. McGraw. 2010 12:35 A M Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Riverview Rehabilitation & Health Cntr. Essex Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days June 28 Months Hours Min 216-36-4029 Mary Land 70 **1**939 Director Usual Residence of Decedent 10a. State ms 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Virginia Avenue 21221 USA ed other than "natural", or items event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Ski Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ William F. McGraw Mildred L. Pearl Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lailani D. McGraw, daughter 100 Virginia Avenue Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/12/10 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence on signed by the attending physician and i be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical I or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The low 124 hours after death.

To the Funeral Director, After this certificate has been significated filled in by the funeral director, page 2 should t 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) IND. February 12, 2010

State

Registrar

21221

Essex. MD

709 Eastern Blvd

32. Régistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malika F. Waseem, M.D.

FEB

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 7 2010 Physician/ 11:10 P C. Elizabeth Maxwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11:10 Harford Bel Air 900 Candle Light Court 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 □ F 92 AOYTY 20 1917 215 09 2440 Pylesville, Maryland **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 02/07/10 permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified a once. Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 900 Candle Light Court 21015 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify Specify: 3 ▼ Widowed 4 □ Divorced White Max wel Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Housekeeping-Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Charlotte May Chapman Edgar Jacob Gladden lizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Woodbury Way Bel Air, Maryland 21014 E. Lyle Maxwell Jr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Metro Crematoy Inc. February 8 2010 Baltimore.Marvland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EF Lassahn Funeral Home PA 24har 11750 Belair Road Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) 9 Medical Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a conscioudness of death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month been signed by the s 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 2 🗌 No Accident Investigation after death the Funeral Directory filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check D within 2 To the F only one the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IIMONIUM 300 rnestine Wright ulaney Date filed (Month, Day, Year) State Registrar

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			1 - For State Registrar	State of Maryland		artment of F tificate of L		-		2010	0373
	Physicia	an/	Decedent's Name (First, Middle, La.	st)				2. Date of De		0,1	3. Time of Death
	Medi	cal	Nancy 4a. Facility Name (if not institution, give	Lou	Mi11			Februa	Ť	8, 2010	1:20 PM
	Examir /	ner	Casey House H			Rockvi	Location of Death			c. County of Death Montgome:	
	Funeral Director		-32 30 ,121	ex 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 1	th ay Year). 4,	9. Birth Cour West	place (State or Foreig http:// Virginia
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County WV Tucker		Town or Loc		<u> </u>				10d. Inside City Limits
	with the M s 23a or 28 ust be noti	Funeral Director	10e. Street and Number Route 219 North			10f. Zip Code 26283			10g. C	Citizen of What Cou	
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If It them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 ▲ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	"	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	
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Maryland 21215-0036	should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med	To Be (17. Father's Name (First, Middle, Last) Ralph Miller			cretary	18. Mother's Name				Insurance
	nd 2 should ealth and M n 27 is mai		19a. Informant's Name/Relationship (7) Roeda Miller - S:	· · · · · ·		- '	and Number or Rura				,
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ፟ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State cer fy) Pars	ons C	sition (Name of atory or other plac Lty Cemet	ery 2-1	Date 16-10	Par	ocation - City or To	
Bal	permit Depar Impor any in		/ / / / / / /	endle		312 Main	s of Facility rb Funera Street Pa	ersons.	wv	26287	
	Physician/ Medical Examiner	her	3a. Frt 1. Inter the disease, or comshock, in heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, hearing to in model.	plications that caused the death. ne cause on each line. Vascular De Due to (or as a conseque) As iration	mentia nce of): Pneum	1	g, such as cardiac o	r respiratory an	rest,		Approximate Interval Between Cnset and Death
092	Attending Physician: The law requires that the death certificate be executed ar death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequent	nce of):						
Box 68	that the death certific ned by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 IX No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live Birth 2 Fetal of 4 Pregnant at time of decentions	death 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of deliv Month	ery Day Year
ds, P.O.	requires that the second representation of th		Part II. Other significant conditions of	ontributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.			use contribute to the	he cause of death?
Division of Vital Records,	s ician: The law re certificate has be irector, page 2 sh	Completed by						1 🗌 Yes	osy orme <u>d</u> ?	prior to co death?	psy findings available impletion of cause of
/ita	nysiciar nis certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ El	D/Outpation	Otha	r: Check			6 K Other (Specify	Hospice
on of \	ending Physath. Pr: After this he funeral di	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work'	at 2	ne 5 🗀 Resid			, rospice
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fr		3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specify)		City or Town		street and Number or Rural Route Number, rn, State)			
		Medical	(Check 2 L Medical Exami	sician: To the best of my knowled ner: On the basis of examination a se Practioner: To the best of my k	and/or investi	gation, in my opinio	n, death occurred at time, date and place	the time, date a	nd place e cause(e, and due to the ca (s) and manner as st	use(s) and manner stat ated.
) 		30. Name and address of person who of		20) (5 2	D0060				oruary 7,	
_	5 V		Bindu Joseph, MD	6001 Muncaste			ockville,	, MD 2	0855	5	
	Sta Registra		31. Date filed (Month, Day, Year) FEB 16 2010	32. Registrar's Signatur		0					
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Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND, ITEM#10e, perfit, G900, 2/16/2010, WS

State of Maryland / Department of Health and Mental Hygiene
amend item 23pt.II Continual of 990 27-26-10 vt

Reg. No. 2 1

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** February 08, 2010 9:05 P M Fannie Lynn Morgan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City 3331 North Chatham Rd. Apt H If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 👿 F 80 219-26-3786 Director 6/20/1939 MAryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiter must be recitived at Ellicott City Howard Maryland 1 ☐ Yes XX No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 3331 N. Chatham Road Apt. H 21042 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 □ Yes 2 ▼No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify 2 3 ☐ Widowed 4 🕅 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Jife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hiant: If item 27 is marked oth Fannie Smith Charles Bischoff ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5320 Night Shade Ct., Columbia, Maryland ,21045 Robin Seitz/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 2/15/2010 Elkridge, Maryland permit. Page Department of Important: If any injury or once, 21. Signature Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) > Syrs Myelofibrosis with bone marrow Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a nonsequence off Hospital or Attending Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed?

1 Yes 2 Xio certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. e Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated To the l 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -11-10 30573 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Micford 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Ella Thompson Murphy аМ 4:35 February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George Morningside House of Laurel Laurel Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🔀 F Months Days Apr. 17, 1913 Hours Min. Director 96 216-44-7743 Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d Inside City Limits must be notified at Director 1 X Yes 2 □ No Prince George Laurel ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a USA 7700 Cherry Lane 20707 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian event, the Medical Examiner Armed Forces? 1 Yes 2 No Black, White etc. ō 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 Ø No Specify. If Yes, Give "natural", 3√Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " U.S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Health & Human Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Woodrow Thompson Mary White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 288 Fairmeadow St., Henderson, Nevada 89012 Robin L. Appello/Grandchild injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Feb. 2010 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P. A. KenSKiles 313 Talbott Ave., Laurel, MD 20707 M01053 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Week Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner years Stage Dementia Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events bunial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be use as the IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 4 Pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? 1 Yes 2 KNo Day Pregnant at time of death detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes �� No 24a, Was an certificate has autopsy Yes 2x xNo Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🐼 No Other: 4 Nursing Home 5 Residence 6 Other Specify Sted Living 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No

68760 Box (P.O. I Records, Division of Vital Hospital or Attending Phys 24 hours after death. Funeral Director: After this filled in by the funeral 24 hours pleted 1 the the

27. Manner of Death

1 № Natural

3 Suicide

29a. Certifier

(Check

29b. Signature and title

4 Homicide

Accident

5 Pending

Investigation

determined

6 Could not be

Certificate:

Medical

To the within State

Robert Maggin, MD, 13952 Baltimore Ave., Laurel, MD 20707 31. Date filed (Month, Day, Year) FEB 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D25422

28d. Describe how injury occurred

City or Town, State

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Day, Year)

February 2, 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		•	For State Registrar		State of	Maryland		artment of H tificate of L		Mental Hy	/giene Reg. No.?	010	03735
	Physicia Media		1. Decedent's Nam James Lowe		Last)					2. Date of De Month Feb 15	eath	Year	3. Time of Death 3:20 A M
	Examir		4a. Facility Name (if	not institution,	give street and number	er)		4b. City, Town, o	Location of Deat	th		ounty of Death	1
	Funeral Director		5. Social Security N 245-24-232	umber 6	dome & Villag 6.Sex 1 XX M 2 □ F	e Age (In yrs. las 83	t birthday) Yrs.	Rockvi If Under 1 Year Months Days	If Under 24 Hrs Hours Min			ntaomery 9. Birth Cou	nplace (State or Foreign Intry) NC
	Aaryland 8a-f show tified at	Funeral Director	Usual Residence of 10a. State MD	10b. County Montgome	ery		Town or Loc	cation	-				10d. Inside City Limits 1 ☐ Yes ※XX No
	th the Na or 2	al Di	10e. Street and Nur	mber				10f. Zip Code			10g. Citize	n of What Cou	untry?
980	e filed within 72 hours after death with the Maryland tal Hyglene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		9701 Veirs 11. Marital Status 1 Never Marr 3 Widowed	ied 2 XX Marri	12. Was Decede Armed Force ed 1 Yes 1 If Yes, Give Year or Date	es? X No	l I	Vas Decedent of H	ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14.	JSA . Race - Ameri Black, White ec <i>ify:</i> W	
Baltimore, Maryland 21215-0036	l within 72 houn ygiene. her than "natu ht, the Medical	Completed by	(Spe Elementary/Sec 12		t's Education st grade completed) College (1-4		(Give I life. D	lent's Usual Occup kind of work done of O NOT use retired) Market Ma	during most of wo	orking		of Business I	ery Store
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Mar	12 shou lith and 27 is m r traum		19a. Informant's Na Bruce McKe		ip (Type, Print)			g Address (Street :				wn, State, Zip	Code)
more,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disp	oosition Cremation	3 Removal from St	ate cer	ce of Dispo	sition (Name of natory or other place Cemetery	ce)	Date . 18,2010	20c. Loca	tion - City or T	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fu K. Greg	neral Service Li ory Fink	MO1148			Name and Addre Fink Funer 426 Crain			, MD 210	061	
	Physician/ Medical Examiner be paragraphed as price as p	dical Examiner	23a. Part 1 Enter is shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list coif any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	inditions, inmediate rlying iinjury s	b. — Due to (or	ised the death. line.) L v m as a consequer as a consequer as a consequer	onice of):		g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
. Box 68760	The law requires that the death certificate be are has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No		th 2 D Fetal on t at time of dea	death 3 🗌	Ectopic pregnand Other (specify)	гу		230	d. Date of deli	very Day Year
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Vita	ysiciar is certii directo	To Be	examiner?	No No	Hospital:	patient 2 🗆 El	R/Outpatien	Oth	er: 4 X Nursing	Home 5 Resi	idence 6 🗆	Other (Specia	fy)
Division of Vital Records,	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	n 5 ☐ Pending Investig 6 ☐ Could r determi	ation ot be	Day, Year)	8b. Time of injury	28c. Injury work M 1 eet, factory, office		28d. Describe			al Route Number,
Divi	ospital or hours afte ineral Dire	Medical Ce	29a. Certifier 1	 ✓ Certifying	Physician: To the bes					and due to the ca			
	To the Ho within 24 To the Fu complete	Med		Certifying	Nurse Practioner: To	the best of my k	rnowledge, c	leath occurred at th	e time, date and p	lace, and due to the	ne cause(s) ar	nd manner as s	Day Vaarl
	0.1		30. Name and addr	`~ -	ho completed cause	of death (Item 2	3a) (Type, P	(rint)	0 5061	2	Febr	rary	15, 2010 20850
	² V Sta	te	31. Date filed (Mont	h, Day, Year)	JALLEN V32. Reg	istrar's Signatur	re		e Kuc	eville"	iary	and	2000
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DHI	/IH 17 Rev 7/2	JU9					-						

ORIGINAL

Baltimore, Maryland 21215-0036

atte be executed be received by Salary Pages 1 and 2 should be filed within 72 hours after death with the Maryland be partitly and Bendel Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Maryland of Salary Sal

Physic /Med

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and a page.

Al va Leonard Mewshaw 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Brooklyn park 4c. County of Death Anne Arundel 5. Social Security Number 1. Social	i. Decedent's Name	o /First Middle I.	and)		Cei	rtificate of De	eath	R. 2. Date of Deat	eg. No?	10	0373
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Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 8, Lillian 2010 6:30 P Α. Meiers February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick MultiCare Center Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 🛠 🖫 F Director 220-18-7859 July 20,1912 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 XX es 2 □ No Director Baltimore City Baltimore City Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be Keswick MultiCare Center 21211 USA 72 hours after death Funeral 700 W. 40th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 25 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Packing Company Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Bramble William H. Meiers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun once. Red Lion, Pennsylvania 17356 PO Box 391 Sandra Lee Mink 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Fallston U. M.Church Cem.2/22/2010 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Juneral Service License Part1. Enter the dise shock, or heart failur 21211 3631 Falls Road Baltimore, Maryland Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Fin disease or condition resulting in death) hyperbusine cardiovasenlar desease earo **Physician** /Medical flue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Basalcile concinous their canther right ein 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed with dreal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No eryeusian 24a, Was an autonsy or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

within 24

State Registrar 29b. Signature and title of certifier

RISMETHE

Dr Babelle The

MOEGREGOR, 700W. 40th STREET, BALTITORE, 70 21211 31. Date filed (Month, Day, Year) 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

thear 50

29c. License number

013657

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Day **Physician** 3 1:05 AM COU /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick multip Baltimore Baltimore are 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1√ M 2□ F Months Days Hours Director 216–16–1183 87 29, 1922 Georgia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm Medical Evaminar must be notified at YYes 2 No Director Maryland N/A Baltimore death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4000 N. Charles Street # 904 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑★★Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evarring once. 1XXXever Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2/XNo Specify. Specify: White ş 3 Widowed 4 Divorced WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Training Supervisor HEW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Roy Fred Matthews Sarah Elizabeth Owen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caleb Tsai 900 Vanderwood Road, Baltimore, Maryland 21228 of Disposition (Name of Date 20c. Location - City or Town, State Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Dona/ion 5 ☐ Other (Specify) Atlantic Crematory 2/16/2010 Glen Burnie, MD 21. Signature of Funeral Service Lic Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Waxlord /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 icate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy certificate 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the I within 2, To the F and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO

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State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Margaret N. McNaney February 14, 2010 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1524 Woodcliff Avenue Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖼 F Days 215-16-7773 Director 11, 1915 94 Sept. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Wedical Evandian in the motified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1524 Woodcliff Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be John Metz Anna Williamson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick McNaney Son 2219 B Lowells Glen Road; Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 2/20/2010 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sevens **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed on attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No Be (25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Medical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the con (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and Frederick Rd Suitell Catonsville 21228 30. Name and address person who completed cause of death (Item 23a) (Type, Print) duis M. 405 2Uni State Registrar

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G900.2/16/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Grace Caroline Matthews 08 2010 February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manor Care- Ruxton Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🔀 F North Carolina 84rs. 1/6/1926 Director 239-30-2214 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Maryland Towson Director 10f. Zip Code 10g. Citizen of What Country?
United States 10e. Street and Number with 21204 28 Allegheny Avenue #1402 items 23a of America "natural", or items 23a filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 ☐ Married Specify: white altimore, Maryland 21215-0036 1 ☐ Yes 🙀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: r than "natura the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Home Health Care the 12 s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) N. Caroline Nicks Luther D. Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau Towson, Maryland 21204 Mrs. Pamella L. Krist/ daughter 28 Allegheny Ave. #1402 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition February 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Fameral Service License Peaceful Alternatives Funeral & Cremation Ctr.,P.A. exto 2325 York Road Timonium, Maryland 21093 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 30 days Jement **Physician** Advant ed Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): Box 68760 attending physician pe Physician/Medical the use as IE FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctapic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has l 1∐ Yes Division or Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a
To the Funeral 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bellong Lane #216. Towson Richard M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

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MATHEWS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marguerite H. Madairy Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Ye Dec. 24. Birthplace (State or Foreign Country)
 Maryland If Under 24 Hrs. ocial Security Number Ade (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🔀 F Days Hours 216-20-2879 84 Yrs Director Usual Residence of Deceden ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Baltimore Park ville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2806 5th Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No Specify. 3 Divorced 4 Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. At Home Elementary/Seconday (0-12) College (1-4 or 5+) Itimore, Maryland 212 Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Alexander W. Wood Amelia E. Gail 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 5th Avenue, Parkville, Maryland 21234 Alva Madairy/ Husbard 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Val ley Memorial 02/13/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Sign sure of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 88.00 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) igned by the aftending physician and be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death been signed by the g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 유 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) death (Item 23a) (Type, Print)

Registrar

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State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** onne /Medical 4a. Facility Name (If not institution, give street and number) City. Town, or Location of Death 4c. County of Death Examiner Season's Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 🗶 F 219-60-6376 57 Director 10 10 52 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show Director MD Baltimore Pikesville 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7204 Chalkstone Drive Apt Bl 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, it a Medical Examination Black, White, etc. within 72 hours after 1 ☐ Never Married 2 🔀 Married 1 □Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 □Yes XI□No Specify. þ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Sales Associate Food Lion na permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Coleman Watson Willie Mae Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7204 Chalkstone Drive Apt Bl, Pikesville, Walter Mallory-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Murial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) King Memorial Park 2/17/10 Woodlawn, Md 21. Signatur- of Funeral Service Licensee March F/H west 4300 Wabash Av Wabash Ave, Baltimore, Md 23a. Part 1. Enter the c sease, or complications that cause shock, or heart failure. List only one cause on each if Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fina disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed and -trar resulting in death) Last physician a s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No After this certificate 2 🗆 No Division of Vital 1 ☐ Yes 1 Tyes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Drath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide The provided in the second of Medical 29a. Certifier completely (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2010 death (Item 23a) (Type, Print) nd address of pers MD 20 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 1 6 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle Day Month **Physician** esruary 2018 11:15 PM rancis 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 248-42-7620 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evertings must be mainted. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State n¶es 2 □ No **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Number 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status d Forces? ∕es 2 ∐ No 1 Never Married 2 Married 1 Yes G Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give King of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Mit Idla Be ၉ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son 1. Box 1213 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune a Service License Yille Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Kespirator **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) ivision of Vital Records, P.O. Box 68760. Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Anema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 □No 1 □Yes 2 📈 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thoatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 3 Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 HIEUT GER VENOUD 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 A AGIVES HUS pital 900 Laton 31. Date filed (Month, Day, Year) /32. Registrar's Signature State FEB 1 6 2010 and -Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florence K. Marronis 1:11 FEBRUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 XF Months Hours 212-30-1558 June 24, 1933 Maryland Director 76 Usual Residence of Decedent mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merlical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 XNo Dundalk 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1757 Inverness Avenue 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 8 vears Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Macy Marsh Carlin P. Kilby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1757 Inverness Avenue, Dundalk, Maryland Nicholas Mavronis Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 12, 2010 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List not one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple organ System Failure Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed Dheumonia the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 N Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or within 24 hours after death.

To the Funeral Director: Aftrownleted filled in by the fur 1 X Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated RES-000 February 8,2010 , MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 V

State Registrar

Registrar
DHMH 17 Rev 7/2009

WACHIRAPON JORDAN Pilyek, MD 4940 Eastern Avenue Baltimore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year randa Fe hovery Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, of Location of Death Examiner 4c. County of Death 100 Johns Her KINS BAUVIEW Hospita +IMU12 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 1 □ M 2 🛛 F Months Days Min 218-64-4835 55 Yrs March **Director** Usual Residence of Decedent per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Baltimore Edgemere Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 7325 Hughes Avenue 21219 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jay Ernest Brittain Sr. Edith Marie Scruggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert McNulty 7325 Hughes Avenue, Edgemere, Maryland Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Maryland Holly Hill Memorial 15, 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md 23a, Parl 1, Enter the dise se. r complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or impury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 this certificate 2 🗆 No 1 Tyes **Division of Vital** 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 1 X Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1) Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

1615/12/16 31. Date filed (Month, Day, Year)

FEB 1 6 2010

Box 68760

Bayview, 4940 Gastern Avenue

Junes, Johns Hookins

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4b,c per doc, 8 per fin god Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 11, 2010 1:55 P Physician/ Frances Hamilton Mitchell Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore Examiner** Towson Howard -Columbia Gilchrist Hospice 8. Date of Birth (Month, Day Ye 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Days Hours Washington, D.C. 1 □ M 2 🖾 F Months 1930 79 Yrs Nov. 213-44-6400 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🖾 No ar than "natural", or items 23a or 28a-f s the Me Ical Examiner must be notified Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 21401 2529 Painter Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Firm Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file n and Mental F is marked of Frances E. Walker ဂ Harry E. Hamilton other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6534 South Wind Circle, Columbia, Maryland 21044 permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Susan Marie Mitchell/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition February 16, Montgomery, crematory or other place)
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 2010 Bethesda, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility Robert A. Pumphrey Funeral RockVille; Maryland 26850 Montgomery Avenue Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder anths Physician/ (anas disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 as the attending properties of a second IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months?
1 Yes 2 No
9 Unknown Day Year To the Hospital or Attending Physician: The law requires that the death Pregnant at time of death been signed by the should be detached 9 I Inknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy cate has l page 2 s performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Division of Vital 4 Nursing Home 5 Residence 6 Nother (Specify) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at n 24 hours arter usus... he Funeral Director: After the inleted filled in by the funera 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 2 Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February 4:30 P M Arthur Bainbridge Mobley 2010 12, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1**K** M 2□ F Months Days Hours Min Yrs. 84 217-22-1412 December 19, 1925 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5909 Rudyard Drive 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Academy of College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Science 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shuman Arthur Moblev Mary Gittinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Claire Mobley/Wife 5909 Rudyard Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Licensee Rollerte And Primphire Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 months End Stage Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Coronary Artery Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IE EEMALE 23d. Date of delivery pregnancy Month Day Year pecify) 23e. Did tobacco use contribute to the cause of death? cause given in Part I. End Stage Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination registed as

and Mental Hygiene.

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

the Maryland

death with

72 hours after

Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical \$

burial-tra physician at the burialattending p for use as signed by the a page certificate

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic 5 ☐ Other (s _i
art II. Other significant conditions	contributing to death but not resulting in t	he underlying o

Complet			24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No		
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Hom	ne 5 Residence 6 Other (Specify)		
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
<u>a</u>	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.		

one)	and manner stated.	
29b. Signature and title of certifier		
Shama	R. Mittaln	W

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D0061382 February 15, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 14816 Physicians Lane, #152, Rockville, Maryland 20850 Shama Mittal, 31. Date filed (Mo 2. Registrar's Signature

State Registrar

Medic

DHMH 17 Rev 1/2001

rector:

To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g900 2-16-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 111 Physician/ 2010 ALVIN J MYERBERG 9:30 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWINGS MILLS BALTIMORE 14 SPRING FOREST COURT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) MD Days Hours Min. 9/211/1925 214-22-4242 84 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 💆 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21117 14 SPRING FOREST COURT filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Force ?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify If Yes, Give Year or Dates Specify: 3 Nidowed 4 □ Divorced WHITE "natural", Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the **DEVELOPER** REAL ESTATE event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be **MYERBERG** CLARA SHARFMAN EDWARD A or other traumatic and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 12016 RIDGE VALLEY DRIVE, OWINGS MILLS, MD 21117 WENDY JACHMAN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗗 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE HEBREW CEM : 2/14/2010 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., Mars 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (ar a) a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy To the Hospital or Attanding Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter compileted filled in by the funeral director, page 2 should be detached for more than 10 per page. in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death? 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature And title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who comp

FEB 1 6 2010

31. Date filed (Month, Day, Year

Richard J. Jones 1650 Orleans St. Rm.

32. Registrar

207 Balto. Md. 21231

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc, 20b per fn g900 2-16-10 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 M Say Sofiya Magnis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BETH COURT OWINGS MILLS BALTIMORE 5. Social Security Number 218-27-0022 If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign 1 M 2 XX Months Days Hours Min. DEC 15 YET 909 OKRAINE Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE OWINGS MILLS 1 Yes 2 No 10f. Zip Code 21117 10e. Street and Nur 10g. Citizen of What Country? 9 BETH COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify Completed 3 X didowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **BOOKKEEPER TEXTILES** Be 17. Father's Name (First, Middle, Last) SHLOMO 18. Mother's Name (First, Middle, Maiden Surname) ည MAGNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 9 BETH COURT; OWINGS MILLS, MD 21117 FAINA ZAFT/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON-CHIZUK AMUNO 2/8/2010 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Dicenses SOL LEVINSON & BROS., 8900 REISTERSTOWN RD: BALTIMORE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on euch line. Approximate Into val Between Onset and Death Immediate Cause (Final disease or condition Physician/ and runas a Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ❤️Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month Day 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred 1 Natural 5 Pending iniun after death Accident Investigation М 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title ause of death (Item 23a) (Type, Print) 30. Name and a ddress of person who completed MOO L 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 23 pt.II per doc g900 2-16-10 vt State of Maryland 7 Department of Health and Mental Hygieffen | 1 1 3 7 5 0

				otato of maryland	Certificate of	Death		leg. No.	03730
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physici /Medio		SONIA RUTH	MISLER			FEBRUAI	RY [™] 9 2011	5:00 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	4c. County of D	eath
1			CHERRYWOOD FUTUR	E CARE		REISTERST		BALTIM	ORE
	Funeral		5. Social Security Number 6. Sex	14	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Pay 6/6/19	Year) 9.1	Birthplace (State or Foreign Country) ME
	Director		220-20-8982	81	Yrs.		6/6/19	28	MD
	pug 🛊		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
	Manyl f ehc	5	MD BALTIMOR	F PIKE	SVILLE				1 ☐ Yes 21 No
	the the table of the table of the table of table	Director	10e. Street and Number	LINE	10f. Zip Code			0g. Citizen of What	Country?
	with With	□	113 RUTH EAGER C	OURT	212	08		USA	
	ms 2:	Funeral			13. Was Decedent of H		city Yes or No-	14. Race - A	merican Indian,
0	offer of	Ē	1 Never Married 2 Married	12. Was Decedent Ever in U,S. Armed Forcee? 1 ☐ Yes 2 ☐ No	If Yes, specify Cub		Rican, etc.)	Black, W	hite, etc.
<u>8</u>	al', o	ğ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 LI Yes 2 1/21 No	Specify:		Specify:	WHITE
5-0	filed within 72 hours efter death with the Maryland Hygiene. ther then "netural; or Items 23e or 28e-f ehow ent, the Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation 1	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of worki	na	16b. Kind of Busine	ss/industry
21	iffin Ben.	ğ	Elementary/Secondary (0-12)	College (1:4or5±)		d)		AIR COND	TTIONING
2	led w lygier her th		47 Feb. 4. No. 4 Find At 111. 1 and	Ĺ	BOOKKEEPER	40 May 1 - 4 - 11	(Fi) A #: 1 # -		TITONTNO
anc	be fi	Be	17. Father's Name (First, Middle, Last) BERNARD	BLOOMBERG		18. Mother's Name	i (riisi, iviidale, i	UNKNOW	N
Ž	should be filed with end Mental Hygiene. is marked other ther eumatic event, the M	2	19a. Informant's Name/Relationship (Ty)		19b. Mailing Address (Street		I Doute Numbe		
Baltimore, Maryland 21215-0020	s 1 end 2 should be filed within 72 hours efter death with the Marylan f Health end Mental Hygiene. It Health end Mental Hygiene. Item 27 is marked other then "netural", or items 23e or 28e-f ehow other treumstic event, tre Wedical Examiner must be notified at	1 8	BRIAN MISLER/SON		113 RUTH EAGE				21208
ē	Health Health Jem 27 i	1 8	20a. Method of Disposition	20b. Plac	e of Disposition (Name of			20c. Location - City	or Town, State
Ω	permit. Pages 1 e Department of Hes Important: If item any injury or othe once.		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		etery, crematory or other pla SHALOM MEM.		/14/10	REISTER	STOWN, MD
=	nit. F artmo ortan Injur		21. Signature of Funeral Service License	1	22. Nama and Addre				
ä	permit. Departn imports any inju		Di Alipert &	ALIANDA					MD 21208
			23a. Part i Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.	Do not enter the mode of dying	ng, such as cardiac o	r respiratory arr	est,	Approximate
*	Physician		shock, or heart failure. List only on	•		/			Interval Between Onset and Death
- A	/Medical		Immediate Cause (Final disease or condition	Gryl	ster Den	renter			Centimores
	Examiner		resulting in death)		s e consequence of):				
	ס ≃	ner			•				3
)	death certificate be executed e ettending physician end ad for use es the bunel-trensit	Examiner	Sequentially list conditions,	Due to (or as	a consequence of):				
60,	be ex cian cian ouriel		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underson in figure			75-45-39			
68760,	cate t	Medicai	that initiated events resulting in death) Last	Due to (or as	a consequence of):				
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Box	eath ce ettendir for use	Physician/						-	
0	the d	ysi	Part II. Other significant conditions con	tributing to death but not resultin	g in the underlying cause given	ven in Part I.			ute to the cause of death?
<u>α</u>	law requires that the de es been signed by the e s 2 should be detached f			(+1)			1 🗆 Y	es 21/No 3L	Probabiy 4 Unknown
of Vital Records,	juires n sigr	d by	1	1 the sim		-	24a. Was a		b. Were autopsy findings
8	w require been si should t	Completed		Ju pur thanks com	Hypertens	sion	perfor	med?	available prior to completion of cause of death?
æ	Ф г 8	E O		Danlado			1□ Y	es 2 No	1 ☐ Yes 2 ☐ No
ta	en: Th rificete stor, pa	a	25. Was case referred to medical	Jumes .		26. Place of Death			
>	Physicien: this certific ral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA Oth	ner:	•	ence 6 Other (S	pecify)
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	b. Time of 28c. Injury Wo	ry at 2	28d. Describe h	ow injury occurred	
. <u>Õ</u>	To the Hospital or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the fune.	atic	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Yes 2□No			
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	2	28f. Location (S City or Town		Rural Route Number,
	ital or rel Dir lled in								
	To the Hospital within 24 hours of To the Funerel Completely filled	edical		er: On the basis of examination					
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	2	9d. Date signed (Me	onth, Day, Year)
	ة ¥ ¥ ك		/-/	A D					
•	_		30. Name and address of person who do	mpleted cause of déath (Item, 23	(Type, Print)	17-1		* ' '	2
	2		person without	1/en Settle	emps 1	838 G	Clano	Tree 1	Al rivos
	Sta	te	31. Date filed (Month, Day, Year)	32 Aegistrar's Signature		V U			
	Registr		FER 1 6 201	1 Cener S.	back				

Amend Item 15 tate of Maryland, Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TEDEVAL 11:29 A.M Ruth M. Moore Medical 4a Facility Name (if not institution, give street and numb BALTIMOR WIShink 44 **Examiner** City, Town, or Lettation of Death County of Death 8. Date of Birth 9. Birthplace (State or Fo Country) Virginia **Funeral** 7 F (Month, Day, Y Aug 29, Months **Director** 1956 231-86-9593 53 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A 7742 Freetown Road permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. the Markes Examination. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. White 1 Never Married 2 Married ð Maryland (21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: -Black Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Restaurant Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Porter Bill Shuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7742 Freetown Road Glen Burnie, Maryland 21060 DeWayne A. Roach, Sr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/12/10 Catonsville, Maryland Metro Crematory, Inc. Signalun J Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 23a. Part 1. Exter the disease, or complications that caused the d shock, or heart failure. List only one caus, on each line. Immediate Cause (Final ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence on). Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 X N Yes Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 X No Other: ၉ 1 \square Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation after death Director:/ the Funeral Directory filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed t (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa re and title of ce 29d. Date signed (Month, Day, 0 2010 and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	ate of Death		Reg.	No.	0
Physic Medical Exam		ERIC LEE McDANIEL				2. Date of Death Month Da February 5, 2	ay Year 2010	3. Time of Death 0603 hrs
1		Facility Name (if not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Lo Baltimore	ocation of Death	-	4c. County of Dea	th
Funeral Director		5. Social Security Number 6. Sex 7. Ag 216-94-0178 1 M 2 F Usual Residence of Decedent	e (In yrs. last bir	thday) If Under 1 Year Months Days Yrs.	If Under 24Hrs. Hours Min.	8. Date of Birth (N	MM/DD/YYYY) 9 B Fore	
·land ·f show any once.	tor	10a. State 10b. County	10c. City, Town	ILLE				10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland liems 23a or 28a-f show	I Director			10f. Zip Code 21206			Citizen of What Co USA	untry?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	13. Was Decedent of Hispa If Yes, specify Cuban, N			14. Race - Ame White, etc.	rican Indian, Black,
136 hin 72 hours e. than "natura	Completed b	AF Developed File and a 10 or		Decedent's Usual Occupation during most of working life. D			b. Kind of Business	/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	L.C. McDANIEL		18	Mother's Name (F	E NEELY	len Surname)	
i, MD 2 and 2 should ealth and M em 27 is m: traumatic e	7	19a. Informant's Name/Relationship (Type, Print) GERALDINE McDANIEL (MOTHE 20a. Method of Disposition	R) :	b. Mailing Address (Street at 2201 WALBROOK of Disposition (Name of ceme	AVE. AP	T 405 BA		MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify: 21. Signature of Fundral Service Licensee JONATA N	te cremate METRO	ory or other place) CREMATORY	2-17	-2010 B	ALTIMORE ERAL HOM	MARYLAND E, P.A.
Physician /M. dirul Examiner		23a. P. i. Enter the disease, or complications that caused al 4re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse	toxicat		ich as cardiac or r			Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a conse						
760, icate be executed physician and the burial - transit	/Medical Ex	d.		f, per ME g90	0 2/23/1	0 тт -		
	sician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcom 1 Live birth 4 Pregnant at the pregnan	e or pregnancy 2		Ectopic pregnanc		23d. Date of deliver Month	y Day Year
IS, P.O. Equires that the den signed by the	ted by Phy	Part II. Other significant conditions contributing to death	but not resulting	in the underlying cause give	en in Part I.	1 Yes 2	No 3 Pro	the cause of death? bably 4 🗹 Unknown
tal Records, sian: The law requirent from the certificate has been sector, page 2 should	Completed	25. Was case referred to medical		26 Plane of	Death (Check onl		prior to	utopsy findings available completion of cause of
of Vit ling Physic After this	on: To Be	examiner?	et 2 ER/Ou y 28b. T	tpatient 3 DOA Oth	her Nursing Hat Work? 28		dence 6 Othe	r.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation Fd 2/5/1 3 Suicide 6 X Could not be determined (Specify)	ıry - At home, far	5:00 am from res om, street, factory, office build at home	ding, etc. 28		tand Number or Ri 1368 Deat , MD	iral Route Number, City
To the Hos within 24 h To the Fur completely	edical	29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of my one) 2 ✓ Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier		vestigation, in my opinion, de	eath occurred at th	ie time, date and j	place, and due to th	e cause(s)
		30. Name and address of person who completed cause of de	oth (How 22-)	29c. License ni O.C.M.I			d. Date signed (Mo	
Ø J		Donna M. Vincenti, MD Assistant Medica 31. Date filed (Month, Day, Year) 32. Jegistrar	al Examiner	111 Penn Street, Ba	altimore, MD	21201		
Regist		FEB 1 © 2010		barker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b,c per fh g900 2-16-10 vt State of Maryland / Department of Health and Mental Hygiene [] 03753 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Month Feb. Physician/ 7:55 PM Afework Negash 6 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Nov. 11, 1942 Country) 67 **Director** 578-15-2319 Ethiopi Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗆 Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Crodyon Ct. #4 20901 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: If Yes, Give 3 ☐ Widowed 4 【 Divorced **Black** Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Public Schools Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery County Monitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Woldu Negash (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Negash / Daughter P.O. Box 11464, Alexandria, VA 22312 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 2-16-10 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
app Funeral and Cremation Services
33 Gist Ave., Silver Spring, MD 21. Signature of run ra Service Licenses 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Colo-Rectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate trace. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown Shock, Acute Renal Failure Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 21 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 1 ☐ Yes 2 🔀 No 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural injury 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause within 24 hor To the Fune completed fi 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MINE D64100 February 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji M.D., 1500 Forest Glen Rd., Silver Spring, MD 31. Date filed (Month, Day, Year) State FEB 16

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:00A M **Physician** 13 2010 Raymond Lee Nelson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Boston Inn Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 1 / 6 / 1 9 3 0 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1⊠M 2□F 143-22-6372 80 New Jersev Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State show item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at Middlesex Metuchen NJ 1 XYes 2 □ No Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 156 Newman St. 08840 USA Funeral 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2**X** No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black "natural", or 1 □Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Long Distance Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Hauling permit. Pages 1 and 2 should be filed be permit of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Nelson Mary Fannie Glasker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 156 Newman St., Metuchen, NJ 08840 Kevin Nelson - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Canaan Cemetery 2-20-2010|Reva, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Funeral Service Lisensee 254 E. Main St., Westminster, MD 21157 Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCVD years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ned by the a detached f ☐Yes 2 ☐No 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \times Other (Specify) BostonHospital: 1⊠ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Inn 1 Natural 2 Accident (Month, Day, Year) 5 Pending investigation e Hospital or Attendin 124 hours after death. e Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar 31. Date filed (Month, Day, Year) FEB 16

JR. MD Herderson 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. fall

29c, License number D0051924

2973

29d. Date signed (Month, Day, Year)

Feb. 15, 2010

Manchester Rd. Manchestra MD 21102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Mary				lental Hyg	iene		
			State Registrar	Cer	tificate of De	eath		leg. No. 2	110.	03755
	Physicia Medic		1. Decedent's Name (First, Middle, Last) ARION A	NICH	OLSON		2. Date of Deal Month	73	Year VOIO	3. Time of Death 00 2 D M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death				4c. County		_
. Agent	<u> </u>		Tate Hospice House		Linthicum last birthday If Under 1 Year If Under 24 Hrs. 8 Date			Anne Arundel		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1 1 M 2 F 85	yrs. last birthday) Yrs.		Hours Min.	8. Date of Birth (Month, Day, Aug 30,	Year) 1924		ace (State or Foreign yland
	I OW	.	Usual Residence of Decedent 10a State 10b, County 10c	02. 7	- atten				10	d. Inside City Limits
	nyland i-f sh ied a	cg.	,	c. City, Town or Lo	cation				100	1 Yes 2 VNo
	or 28a notif	Director	MD Anne Arundel 10e. Street and Number	Hanover	10f. Zip Code		-	10g. Citizen of	What Countr	
	with th		lll Reavis Road		21076			U.S.A		<i></i>
	tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever	n U.S. 13. \	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-		ce - Americai	
36	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Armed Forces? 1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates.		Yes 2XXNo		Thouri, etc.,	Specify	ck, White, et :: Whi	
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and	ntal Hy ed oth event:	10 B	17. Father's Name <i>(First, Middle, Last)</i> Edgar Herbert Souder		1	8. Mother's Name Mary A.		vlaiden Surnam	ie)	
Ž	should be file and Mental I 7 is marked c raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and			City or Town.	State. Zio Co	nde)
Ma	12 shulth ar 27 is r trau		Diane Dee Richmond / grandda	L L	111 Reavis		Hanover,	_		1076
re,	of and 2 should be of Health and Ments fitem 27 is marked rother traumatic er		20a. Method of Disposition 2	0b. Place of Dispo			Date	20c. Location	- City or Tow	n, State
imo	Page nent c ant: It ury or		1 ∰urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) □	3.	Church Cem	ı. 2/1	7/2010	Scaggs	ville,	MD
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If it any injury or of		21. Signature of Ferrerat Service Licensee M0		. Name and Address onaldson F 13 Talbott				land	20707
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Box 687	ith cer ittendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver onth [y Day Year
	ag ag	Physician/Me	1 Yes 2 No 4 Pregnant at till 9 Unknown 9 Unknown	le of death 5 L						
P.O.	Attending Physician: The law requires that the de: ar death. ector: After this certificate has been signed by the a by the funeral director, page 2 should be detached	by Pi	Part II. Other significant conditions contributing to death but n	ot resulting in the u	ınderlying cause giver	n in Part I.	23e. Did to	bacco use con	tribute to the	cause of death?
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Ž	Phys this ral dir	2	1 ☐ Yes 2 No Pospital. 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatie	nt 3 🗆 DOA	4 U Nursing Ho	ome 5 Resid 28d. Describe ho			HOSPICE
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Division	r Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury-building, etc. (S,	At home, farm, str	eet, factory, office		28f. Location (S City or Town		ber or Rural F	Route Number,
٥	Hospital or 24 hours afte Funeral Dir eted filled in I		29a, Certifier 1 Certifying Physician: To the best of my		occured at the time, o	late and place, an			ner as stated	<u> </u>
	o	Medical	(Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the besi	ination and/or inves	tigation, in my opinion, death occurred at the t	, death occurred at ime, date and plac	t the time, date and the tothe	nd place, and du e cause(s) and m	ue to the caus nanner as stat	se(s) and manner stated. ted.
a	To the within com		29b. Signature and title of certifier	1 m	29c. License r	2143	8	Selv Selv	man	4152010
	i DV		30. Name and address of person who completed cause of death	(Item 23a) (Type, I	Print) DEF	ENSE A	TAHWA	y ANN	APOLI	SMOZIYUI
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's	Signature				-(
H	Registr	ar	FEB 1 6 2010 2	1. 60	Al .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c Per FH G900 2/24/2010 JH
State of Maryland / Department of Health and Mental Hygiene amend #12&20c Per FH G901 3/3010 JH
Reg. No. 2 | 1 | 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 2010 1:00 A M Albert Eugene New /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11813 Farmland Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 4, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠** M 2□ F Yrs 74 509-36-2878 Kansas Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modest Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 11813 Farmland Drive United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ½ Yes 2 □ No 1960 — If Yes, Give — 1973 Year or Dates: 1986 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Research and Laboratory 12 should be filed within h and Mental Hyglene. 7 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 5+ Animal Medicine Veterinarian permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othnany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be New Ethel L. Albert Edwin Hanson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deena M. New /Wife 11813 Farmland Drive, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20a Location - Gity or Town, State

Betnesda Maryland Montgomery Crematorium Metropolitan Crematory Feb.23 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Virginia | 2010 4 ☐ Donation 5 ☐ Other (Specify) 19, 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Mystetle Bryant M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Attending Physiclan: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Physician/Medical aftending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ∐Yes 2 ∐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1 ☐ Yes 2 🖾 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗆 Nursing Home 5 🖾 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

Division of Vital Records,

P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

Lori Reitman, M.D.

FEB 1 6 2010

29b. Signature and title of certifier

14955 Shady Grove Road, #100, Rockville, Maryland 20850 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Jay Harvey O'Connor February 7 2010 12:15 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 14639 Bauer Drive #316 Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Months Days Hours Min 1⊠ M 2□ F 82 August 9, 1927 Washington, DC 578-40-6139 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Rockville <u> Maryland| Montgomery</u> 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 14639 Bauer Drive #316 20853 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No White If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Printing Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph J. O'Connor Margaret Bolles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret O'Connor/Daughter 13061 Smithneck Road, Carrollton, Virginia 23314 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 12, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee 300 West Montgomery Avenue, Rockville, Maryland 20850 M01548 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lung Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Completed Certification: To 2 after death Director: filled in by

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art II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □Yes 2 ☒No 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
5. Was case referred to medical	26. Place of De	eath (Check only one)
examiner? 1⊠Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☑ Residence 6 ☐ Other (Specify)
7. Manner of Death 1 ॲ Natural 5 □ Pendin 2 □ Accident investig	ation M 1 LI Yes 2 LI No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could in determ		28f. Location (Street and Number or Rural Route Number, City or Town, State)

24 hours a Funeral L the Hospital within 2, To the F

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier noizemes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ata Motamedi, M.D. 18111 Prince Philip Drive #201, Olney, Maryland 20832

31. Date filed (Month, Day, Year) FEB 1 6 2010

29a. Certifier

(Check only

Medical

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 💉

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nd 2 shoule ealth and N m 27 is me		19a. Informant's Name/Relationship (Type, Print) Carolyn L. Wisenauer (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 819 Lynvue Rd. Linthicum, Md. 21090									Code)	
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■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 5, 2010 7:01 A Elizabeth H. Phipps Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months (Month, Day, Year 83 214-22-0212 Director 4,1926 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nigury or other traumatic event, the Medical Examiner must be notified at once. 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Jarrettsville 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2204 Nodleigh Terrace 21084 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces ģ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army Corp Supervisor 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arnold J. Eicholtz Mary C. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Nodleigh Terrace-Jarrettsville, MD Bernard Phipps-spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wilson United Methodis 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Endral h ME Forde Evans Funeral Chapel and Cremation Services Newport Drive-Forest Hill Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? cate has t performed? Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗶 No 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and agdress of derson who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	aryland / Depa Cer	artment of F <i>tificate of L</i>		∕lental Hy	- /1	010	037	62
	Physicia	an/	1. Decedent's Name (First, Middle,	_ast)				2. Date of De	Reg. No.	V	3. Time of De	eath
-	Medi Examir	cal	JAMES 4a. Facility Name (if not institution, g	live street and number)	_ PETE	A Situ Town or	Location of Death	Febru			3:31	ρ.м
ر.	LAGIIII		SAINT JOSEF	PH MEDICA	L CENTER	4b. City, lown, or	Tows	ON	4c, County	of Death	ORE	
	Funeral Director		10/06 2141	i. Sex 7. Ago 1 A M 2 □ F	e (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month), Da	th I		ce (State or Fo	oreign N.T
	and show fat	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	cation				100	I. Inside City L	imits
	Maryli 28a-f notified	irect		MORE	Ph	DENIX					1 🗆 Yes 2	X No
	with the 23a or 1st be	Funeral Director	10e. Street and Number 4004 Eland	Oard		10f. Zip Code	131		10g. Citizen of	What Country	?	
	death r items iner mu	FE	11. Marital Status	12. Was Decedent E Armed Forces?	If	Vas Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American		
9036	if filed within 72 hours after death with the Maryland tal Hygene. dother than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 🗖 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 X Yes 2 I If Yes, Give Year or Dates.	No 1	☐ Yes 2 No	Specify:	,	1	white, etc		
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Maryland	ould be filed d Mental H marked ot matic even	To Be	17. Father's Name (First, Middle, Las	Edward	PETERS		18. Mother's Name		Maiden Surname	e)		
lary	should and M is mar		19a. Informant's Name/Relationship	(Type, Print)			nd Number or Rura	_		tate, Zip Coc	de)	
	1 and 2 if Health item 27 other tr		ELSA PETERSO1 20a. Method of Disposition	V-WIFE	4005 20b. Place of Dispos	ELAND Sition (Name of		Date Date		2/13/	0	
<u>m</u>	e + + ≥		1 ☐ Burial 2 🖟 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State		atory or other place	9) 1 11	1 1	20c. Location -	26.26		
Baltimore,	permit. Pag Departmen Important: any injury once.	i	21. Signature Funeral Service Lice	nsee 1 1 1	22.	Name and Address	s of Facility (CA)	4 YORK	KOAD, A	CONKTO	N, MD.	
			23a. Part 1. Enter the display or co	profications that caused	the death. Do not enter	THE mode of dying) ERACHA , such as cardiac o	r respiratory arr	<i>EMAT701</i> est,		CES-MO	NETON
	Physician/	e P	shock, or heart failure. List only Immediate Cause (Final disease or condition	_a. Resp	irator	V AT	rest			l In	terval Betweer nset and Deatl	
	Medical Examiner		resulting in death)	Due to (or a	consequence of):	ONATI	1 440	ortol	usio	A		
	p #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):	7	X II Y P		93101			
X	execute in and ial-tran	Exa	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					_		
3	cate be executed physician and the burial-transit	edical Examiner		■ d	y 25 K							
200	ending use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy	Estacia eregnana			23d. Date	e of delivery		
. BOX	ding Prysician: The law requires that the death certific. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	4 Pregnant at 9 Unknown		Other (specify)			Mor	nth Da	y Year	
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Lec Lec	The law ate has bage 2	omo						24a. Was a autop: perfor	sy p	vere autopsy rior to compl eath?	findings availa etion of cause	of
<u>a</u>	sician: certifica rector, I	Ba	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		0.11	ce of Death (Check	only one)			_ NO	17
>	ng Phys ter this neral di	te: To	27. Manner of Death	1 ☐ Inpatier 28a. Date of injury (Month, Day,	ent 2 🗷 ER/Outpatient / 28b. Time of injury	28c. Injury	4 □ Nursing Hor at 2		ence 6 Other			\dashv
DIVISION	death. ctor: Af y the fu	ertificate:	2 Accident Investigati 3 Suicide 6 Could not	on be 280 Place of Injur	y - At home, farm, stree		es 2 🗆 No	2011 11 12				
	ral or rains after al Direction by led in b	0	4 Homicide determine	building, etc.		r, lactory, office	1	City or Towr	reet and Number , State)	r or Rural Ro	ite Number,	į.
\	or the nospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Uneck 2 L. Medical Exar	ysician: To the best of m niner: On the basis of exa irse Practioner: To the b	amination and/or investio	ation, in my oninion	death occurred at t	he time date an	diplace and due	to the course	s) and manner s	stated.
\ ;	vithin To the		29b. Signature and title of certifier	rse Fractioner: To trie b	est of my knowledge, de	29c. License			cause(s) and mar 9d. Date signed			\dashv
			20 Name and address of	Krentin	2,770	D64	1300		Februar	ry, 09	,201	0
			30. Name and address of person who	conthal	ath (Item 23a) (Type, Pri		- Drive	Tows	on, Ma	sykin.	1 212	104
	State Registra	e r	31. Date filed (Month Pay Year) FEB 16 2	010 32 Registrar	s Signatur	Wed .				7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. C Certificate of Death 1. Decedent's Name (First, Middle, Last 3. Time of Death 2. Date of Death 2010 Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death 4c. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min 1□M 2♥F Months Days Hours Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 □Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑No Specify. 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. PO NOT use retired) HOMP WAKER Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a, Part 1. Enter the risease, shock, or heart silure. List Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. accident Immediate Cause (Final ACN erebrovascu disease or condition resulting in death) Due to (or as a consequence of) Nears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Month Vear 5 Other (specify) 9 TIInknown 23e. Did tobacco use contribute to the cause of death? nditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 (No Aja רע פ 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Othe 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury Work?

Physician /Medical Examiner law requires that the death certificate be executed sician and burial-tran

P.O. Box 68760,

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Inpepartment of Health and Mental Hygiene. Inpertant: If item 27 Is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Mudical Examiner must be notified anone.

Baltimore, Maryland 21215-00

attending physician for use as the buria signed by the a page 2 s director

in the past 12 months? 1 □Yes 2 □No 9 □ Unknown
Part II. Other significant con

er: 4 ☐ Nursing H	lome	5 🗆 Residence	6 € Other (Specify) AL
at at	28d.	Describe how init	urv occurred	

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only
one)

1 🖪 Natural

2 Accident

3 Suicide

4 Homicide

1 🗾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number DO0614 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bushing I. AL-Azzawi, MD, 9103 Franktin Square Drive, Smite

State Registrar 31. Date filed (Month, Day, Year) FEB 1 6 2010



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral or

To the Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PARKER Month EB 2010 08:20 PM Medical Examiner 4c. County of Death Health 11:cot+(Howar 9. Birthplace (State or Foreign Date of Birth **Funeral** Months Country) Director show ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥Yes 2 ☐ No More 10g. Citizen of What Country? Completed by Funeral death Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industr (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than VSeconday (0-12) College (1-4 or 5+) bmestic Be Father's Name (First, Middle, Last) ပ ic 194. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition Department of H Important: If ite any injury or ot Date Burial 2 ☐ Cremation 3 ☐ Removal from State -19-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig the of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CARDIO PULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DEMER Gaquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): HYPERTENSION for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical WEAKMESS MISCULAR IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AMEMIA 1 Yes 2 No 3 Probably 4 Unknown DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work?
1 Yes 2 No ↑ Natural iniury 5 Pending **Divisioh** 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 □ the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) PHYSICIAN D 0062704 0105,2010 of person who completed cause of death (Item 23a) (Type, Print) ELLiCOH Ridge Shire 100 KTP Road 3290 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08/2010 PLOVSKY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner COURTLAND GARDENS PIKESVILL BALTIMORE Birthplace (State or Foreign Country) Year If Units 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1072871922 1 XM 2 ☐ F 88 Yrs. POLAND 219**-**05-7623 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State sa or 28a-f show t be notified at 1 ☐ Yes 2 🗖 No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must b 2 POMONA EAST, #206 21208 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Year or Dates: WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) r than College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 Is marked other thar any injury or other traumatic event, the Mones. SELF EMPLOYED CONTRACTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN 2 PLOVSKY BESSIE KALANSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HELENE P GERSCH 14911 BEECHURST DRIVE, HOUSTON, TX 77062 of Disposition (Name of Date 20c. Location - City or Town, State DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 2/15/2010 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. 21. Signature of Funeral Service Lice se SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) me **Physician** /Medical Due to (or as a consiquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and , page 2 should be detached for use as the burial-trar the attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2□ No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: Hospital: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **X**No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural ∠ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HARRIET **PECK** FEBRUARY 01:14P M 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛣 F 192-03-3125 91 07/20/1918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1450 BEDFORD AVENUE, #618 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🗖 No þ 3 ☐ Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 TECHNICIAN BEAUTY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAHAM CHUSSITT 2 anna PERCOFF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES PECK / HUSBAND <u>1450 BEDFORD AVENUE, #618, BALTIMORE, MD 21208</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) DRUID RIDGE CEMETERY 2/15/2010 PIKESVILLE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months le to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Physician/Medical þ Completed Be

Physician /Medical **Examiner**

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr.

Baltimore, Maryland 21215-0036

r 28a-f show notified at

ms 23a or 7

the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 page 2 s

Certification: To

cause. Enter Underlying Cause (Disease or in ijury that initiated events resulting in death) Last	Due to (or as a consequence of	yf):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of deli Month	very Day Year
Part II. Other significant conditions con	0 1 0	A	iven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
				24a. Was an autopsy performed? 1∐ Yes 2	prior to death?	topsy findings available ompletion of cause of 2□ No
25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
1 Yes 2 No	lospital: 1	patient 3 DOA O	ther: 4 ursing Ho	me 5 Residence	6 ☐Other (Spec	city)
27. Manner of Death 1				28d. Describe how inj	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Location (Street a City or Town, Sta	and Number or Ru lite)	ral Route Number,
29a. Certifier (Check only one) 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and and magner stated.	, death occurred at the d/or investigation, in my	time, date and place, opinion, death occurr	and due to the causered at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
29b. Signature and title of certifier	Lym	29c. Licer	se number	29d. E	Date signed (Month) $10/20$	n, Day, Year)
30. Name and address of person who co	impleted cause of death (Item 23a) (Type, Print)		,	V	

State Registrar

DHMH 17 Rev 1/2001

Medical

n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in th

within 24 hor

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completely f

32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Year Quinlan Feb 2010 12 50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harbor Hospital Himore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Yea 1 ₩ M 2 □ F Months Days Hours Min. Maryland 74 Director 216-30-6635 Jun. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No MD Baltimore <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2307 Brohawn Avenue United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 autr and Mental Hygiene.
27 is marked other than "natural", traumatic event. the ***. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Franklin Quinlan Alice Mercin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Mary Quinlan - Wife 2307 Brohawn Avenue, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 2-16-2010 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CV disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death
☐ Unknown Month been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Pentricular Tachycardia Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy rmed? 2 No death? certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Matural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Cerifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover Street Baltimore MD David Scheruga Do 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, La 2. Date of Death Day **Physician** Year 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner tow last birthday) **Funeral** Days Months Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Examina", ust be neithing an once. 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Baltimore Randallstown Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Branchleigh 21133 9837 by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entrepveneur 2th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Quill Parker lulia 19a. Informant's Name/Relationship (Type. Print, 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9837 Branchleigh Road Pandallstown MD21133 Shirley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 02/16/2010 Arbutus Vaugh C. Gircene Funeral Services 21. Signature of Funeral Service Licensee Randallstown MD21133 Liberty Koard 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) וסומים שונים אופר this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) our 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03769 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peter Reale Month Medical 18/ 2010 7:15am[™] 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/23/20 1**XX**M 2 □ F Months Days Hours Min. 89 360-05-5509 Director Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NJ Ocean Whiting 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Lilac Lane 523 B 08759 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1XXYes 2 ☐ No 1XXYes Black, White, etc. 1 Never Married 2 Married WWII þ Maryland 21215-0036 1 ☐ Yes 2XX No Specify: white If Yes, Give "natural", Specify: 3 ₩Vidowed 4 □ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MAnufacturing Foreman 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Eloise Moretti 2 Vincent Reale other traumatic should I and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Jacala Terrace, Rockville MD 20850 Ronald Reale / Son and 2 s f Health item 27 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Fairview Cemetery 2/12/10 Westfield, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor P Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 1005 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myelodysolasia Medical resulting in death) Examiner Acute Myeloid Leukemia Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed Severe Anemia and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 as asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perforn certificate Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 1 🗌 Yes 2 🛛 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. injury at 28b. Time of Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending Accident 1 🗌 Yeş 2 🗌 No after death Director; A d in by the f Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined i 24 hours after e Funeral Dire leted filled in b City or Town, State) Medical

State

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29a. Certifier

only one)

3 [

NIMES

29b. Signature and title of certifier

50 W. Edmonston Dr., Suite 207, Rockville MD 20852 Thomas V. Joseph, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 16 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MUNES

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0047330

29d. Date signed (Month, Day, Year) 2/9/10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / State of Maryland /		artment of H			ene g. No. 2011	1 03770
			Decedent's Name (First, Middle, Last)				2. Date of Death	-	3. Time of Death
	Physici /Medio		Colleen Trina Richmond				Month Februar	Day Year Year 2010	1:15 A M
and of	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
تعميد			4554 Sixes Road			Frederick		Calvert	
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/28/19	Year) 9. Bir	thplace (State or Foreign ountry)
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	yland Now		10a. State 10b. County 10c. City, Tow	n or Lo	cation				10d. Inside City Limits
	a-fsh	cto	MD Calvert Princ	e Fi	rederick				1 X Yes 2□No
	or 28	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	
	ath w	ra	4554 Sixes Road		20678			U.S.A	•
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modical Eventher must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Vas Decedent of His fYes, specify Cuban □Yes 2KNo	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
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Mar	h and h and h land							City or Town, State, .	Zip Code)
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ä	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, IT. ADDE.		1504	75	522 Connel	Ana	tomy Gif	ts Regist Hanover,	ry
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~.	Physician /		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MALNUTKI H	לאט	/ cach	wia			Interval Between Onset and Death
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5	aw requir is been si 2 should I	olete	SIP totacheas toming				24a. Was an	24b. Were au	itopsy findings available
בֿ į	: The law cate has page 2 :	Completed	0				autopsy performe 1 🗆 Yes 2	l prior to	completion of cause of
<u>.</u>	ifcian: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?			26. Place of Death		QNO ILITES	21,200
5 i	hysic this of	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Or	utpatient	3 □ DOA Other	· 4 ☐ Nursing Hom	ne 5 Residenc	ce 6 ☐ Other (Spe	cify)
	iding Physician: th. After this certifical funeral director, p			Time of njury	28c. Injury : Work?		8d. Describe how	injury occurred	
<u>.</u>	ttend death ttor: / the f	icati	2 Accident investigation			es 2□No			
3	after after Direc	Certification:	4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre	ет, тастогу, опісе	2	City or Town, S	et and Number or Ri State)	ıral Route Number,
7	spita nours neral / fillec		29a. Certiffier 1 Certifying Physician: To the best of my knowledge	e, death	occurred at the time	e, date and place, a	nd due to the cau	ise(s) and manner a	s stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examiner: On the basis of examination ar	id/or inv	estigation, in my opi	nion, death occurre	d at the time, date	e and place, and due	to the cause(s)
	vithi To th	ž	29b. Signature and title of certifier		29c. License	number	29d	I. Date signed (Mont	h, Day, Year)
			Kareniga L. Kemmonis, Mu	ο,	Doo	3/7//		2/9/10	
			30. Name and address of person who completed cause of death (Item 23a)	(Type, F	Print)		1	~ ~ ~	
			Kaneyca R Lemmons, 40 301	Stee	ple Char	e Dr. Si	ute 10	3, Prence	- Frederik hed
	Stat Registra	e ar	29b. Signature and title of certifier Kareniga L. Seimmonls, rug 30. Name and address of person who completed cause of death (Item 23a) Kanenca R Lemmonls to 301 31. Date filed Moath Day Year) 32. Jegistrar's Signature Amount J.	Bo	wed				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ FEB 7. 2010 7:25 PM Mary A. Reinhardt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manor Care Silver Spring Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 25 3 JUN 24, 1927 **Director** 199-22-7885 82 Vrs Pennsylvania Usual Residence of Decedent 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 28a-f 1 Yes & No Maryland Montgomery Silver Spring 10f. Zip Code 20904 ō 10e. Street and Number 10g. Citizen of What Country? United States 2501 Musgrove Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 2 Widowed 4 Divorced Year or Dates the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Medical Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever and 2 should be Stephan Andrevich Stephanie Kasody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Lisa M. Colburn/Daughter B8 S. River Rd., Front Royal, VA 22630 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 & Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/9/2010 Beltsville, Maryland 21. Signature of Funeral Savice Licensee Name and Address of Facility Rapp Funeral & 935 Gist Ave., M00382 Cremation Services Silver Spring, MD the Alma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Multiorgan Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Anemia Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arthiritis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dementia 24a. Was an cate has page 2 s autopsv perform After this certificate Division of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 😾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After the 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 🕻 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Raman R.

31. Date filed (Month, Day, Year)

Tuli M.D.

FEB 1 6 2010

10810 Darnestown Rd. #202, Gaithersburg, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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					-			-

4			te of Death		eg. No.	0 03/1
Physicia Medical Exami		Catherine Kockstron		2. Date of Deat Month February 8	h Day Year	3. Time of Oeath 1812 hrs
		Facility Name (if not institution, give street and number) Royal Court Drive	4b. City, Town, or Location of Dea Woodlawn	th	4c. County of Death Baltimore Cou	nty
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24H Months Cays Hours M Yrs.		th(MM/00/YYYY) 9. Birth	nplace (State or
Maryland 28a-f show any d <u>at once.</u>	tor	10a. State 10b. County 10c. City, Town o	salawn	,		10d. Inside City Limits 1 Ses 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	al Director		101. Zip Code 21207		og. Citizen of What Coun	try?
b	by Funeral	3 Widowed 4 Divorced If Yes, Give Yeer	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puerland Yes 2 No specify:		14. Race - Americ White, etc. Specify: W	an Indian, Black,
1215-0036 d be filed within 72 hours after fental Hygiene. tarked other than "natural", c event, the Medical Examiner	Completed I		ecedent's Usual Occupation (Give kind of uring most of working life. 00 NOT use re		16b. Kind of Business/In	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Albert Kockstron	18.Mother's Nam	ne (First, Middle, M	terr	
MD and 2 sho saith and em 27 is raumati	2	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,		ber, City or Town, State, Vitaliana 20c. Location - City or T	, MD 21207
Baltimore permit. Pages 1 a Department of He Important: If it		1 Donation 5 Other Specify: 21. Signature of Funersh Sovice Licensee	y or other place) AWW Lemetry 2 22. Name and Address of Fa. Ity	121/2010	Baltine	12, MD
Physician		23a. Part I. Enter the disease, or complications that caused the death. Oo not failure. List only one cause on each line.	HOURS FUNCTAL H. enter the mode of dying, such as cardiac	amo 40	100 Liberty	1 . 01 1-1
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Smoke Inhalation and Carbon Due to (or as a consequence of):	Monoxide Intoxication			Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last				
760, icate be executed physician and the burial - transit						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical		Fetal death 3 Ectopic pregr	nancy	23d. Date of delivery Month Da	ay Year
, P.O. Box 68 res that the death certification is greed by the attending be detached for use as the	اھ		n the underlying cause given in Part I.		pacco use contribute to the 2 V No 3 Proba	
ecords, he law requir te has been s	Completed			24a. Was a autops perform	prior to co ned? death?	ppsy findings available mpletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s	Becc	25. Was case referred to medical examiner?	26 Place of Death (Check	only one)	No 1 Yes	
Division of Vital Records, ta or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	유	1 Ves 2 No 1 Impater 2 Errout 27. Manner of Death 1 Natural 5 Pending Feb 8, 2010 No 1 Payear) 1 Natural 1 Pending Feb 8, 2010 No 1 Payear) 1 Natural 1 Pending Feb 8, 2010 No 1 Payear)	me of Injury 28c. Injury at Work?		Residence 6 Other: ow injury occurred House Fire	Scene
Division spital or Attenchours after death hours after death neral Director:	Certification:	4 Homicide determined (Specify) Single Family Ho		or Town, St 2025 Royal Co	urt Drive, Woodlawn,	MD
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	23d Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, an estigation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stated and place, and due to the	i. cause(s)
→ ŏ		29b. Signature and the of certifier Leke MOS	O.C.M.E.		29d. Oate signed (Mont February 9, 2010	h, Day, Year)
	- 1		11 Penn Street, Baltimore, MD	21201		
Sta Regist	ate rar		Kances			
DHMH 17 Rev 1/20	001	OCME ORIC	GINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

George Leon	ard F	٠.	I- For State	tate of Mar	yland / [Departm	ent of He ate of De	alth and	Mental I	Hygiene		10 037	7
Phys		1/	Registrar 1. Decedent's Name (First, Midd			Octano	ale of De	aur		2. Date of De		3. Time of Death	
Medical Exa	mine		GEORGE LEONAR 4a. Facility Name (if not instituti				I dh Ci	ty Town or L	ocation of Dea		y 7, 2010 4c. County o	1640 nrs	
			9601 Old Harford Ro	-	(Hamber)			Itimore	ocation of Dea		Baltimore		
Funer Direct			5. Social Security Number 215~32~8167	6. Sex	0.7	n yrs. last birl	Mo	Inder 1 Year onths Days	If Under 24H Hours M		3irth(MM/DD/YYYY) 17,1928	Birthplace (State or Foreign M.d.	_
		}	Usual Residence of Decedent	1 ^ M 2	F 01		Yrs.			Aug.	17,1020	Country) Md.	
w any		- 1	10a. State 10b. County laryland Balt	imore	100	c. City, Town	or Location						
ıryland Sa-f sho	Director	<u>i</u>	10e. Street and Number	TIIIOT 6		_	10f.	Zip Code	more co		10g. Citizen of Wha	1 Yes 2 X	No
ith the Maryland 23a or 28a-f show	Dir.		2800 Cub Hill	Rd.				2123	USA	USA			
ath with	nust be no	le la	11. Marital Status 1 Never Married 2 N		Decedent Eve 1 Forces?					Specify Yes or N to Rican, etc.)	No- 14. Race - White,	- American Indian, Black, etc.	
ufter de: Il", or i	v Fig	-		1 Ye vorced If Yes, Give				Yes 2X No specify:			_{Specify:} White		
hours a	Examine Pod by		15. Decedent's Education (Spe			ted) 16a.	Decedent's Usi during most of	ual Occupation	n (Give kind o		16b. Kind of Bus Farming-		
036 thin 72 ne.	the Medical Exam		Elementary/Secondary (0-12)	1	(1-4 or 5+) / A		Farmer			,	Employed		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	event, the Medical Examiner O Be Completed by E		17. Father's Name (First, Middle, Last) George Leonard Rye, Sr.					18	Mother's Nan	ne (First, Middle,	, Maiden Surname) Carelina- Wackerhauser		
212 ould be Mental	C event,		19a. Informant's Name/Relations	ship (Type, Print)	-	198	o. Mailing Addr	ess (Street a	and Number or	Rural Route Nu	aroline umber, City or Town	. State. Zip Code)	
MD nd 2 sho alth and	aumat		Ruth S. Rye (S	ister)		128	300 Cub	Hill F	Rd. Bal	timore,	Md. 2123	34 	
Baltimore, permit. Pages I a Department of He Important: If ite	other tr	ľ	Burial 2 Cremation	n 3 Remova	I from State	cremate	of Disposition (I ory or other pla VOOD CE	ice)		Date .3~2010	Baltimor	City or Town, State	
altim mit. Pa partmer portan	ury or	-	4 Donation 5 Other S Ch Signature of Funeral Service									•	
			Mother To	Dem (2)		7401	Belair	Rd. B	ome altimor	e, Md. 21	236	
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30x 68760, death certificate be attending physic	sician/Me	2:	3b. Was decedent pregnant in the past 12 months?	ne 1 Live	birth gnant at time	2 of death	=		Ectopic pregn	ancy	Month	Day Year	
Box 68760 to death certificate be triple attending physical trip	Physic		Yes 2 No 9 Uni	(noum	known	ordeau 5	Other (S	pecify)					
	by P		Part II. Other significant condit	ions contributing	to death but	not resulting	in the underly	ing cause give	en in Part I.	1		ute to the cause of death? Probably 4 Unknow	—
Division of Vital Records, P.O. fall or Attending Physician: The law requires that the safter death. The property of the property of the second of the property of the proper	Completed									24a. Was	an 24b. We	ere autopsy findings availa	ble
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ion of trending leath. tor: Al	ation		1 Natural 5 Pend 2 ✓ Accident Inves	found stigation Feb 7	nth, Day,Year) D: 2010	FOUI 1615	ND:	1 Yes			posed to cold		
Divisior al or Attend s after death	Certification:		Suicide 6 Coul	d not be 28e. Pl	Behind		rm, street, facto	ory, office build	ding, etc.	or Town,	State)	or Rural Route Number, C	ity
To the Hospital Within 24 hours	edical Certification: T	2	Homicide	Topcon			th occurred at t	he time, date	and place, and		rford Road, Baltim se(s) and manner as		
To the To the	Medical	0	ne) 2 Medical Exa	miner:On the basi and manne	s of examinat	tion and/or in	vestigation, in	my opinion, de	eath occurred	at the time, date	and place, and due	to the cause(s)	
	2		9b. Signature and title of certifie	Vio			2	9c. License n O.C.M.I			29d. Date signed February 8, 2	(Month, Day, Year)	
		3	Name and address of person			(Item 23a)					1		_
	State	3		nt Medical Ex	aminer Registrar's Si		Street, Ba	ltimore, ME	21201				
Regi	State istrai	r Š	1. Date filed with Day, Year	010 Sen	WAL.		and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 23:0< PM Luise Vida Reichert Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Squa 50 anklin mose 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days 0471171915 Director 218-01-1256 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code items 23a or ner must be 10g. Citizen of What Country? Funeral 9516 Belair Road 21236 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Charles Reichert Secretary Builders Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gustav M. Biedermann Bertha W. Buehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Reichert 9516 Belair Road - Nottingham, Maryland any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Michael Luth.Cem.02/18/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 220 ata disease or condition resulting in death) Medical Examiner 25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence f): physician and the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Dav Year Unknown 9 Unknown has been signed by e 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other: 욘 1 Inpatient 2 ER/Outpatient 3 I this 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my colors, death occurred at the time. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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32. Registi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -- Month Ken Medical rebruary 4a. Faqility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ka Kins (enter ledica ! timore **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 M 2 XF Months Days Hours Min. 72 0292571937 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27.5 is marked of ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland N/A Raltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2002 Gough Street 21231 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: White 3 Divorced Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard Czarnecki Mary Dombrowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Rehling - Husband 2002 Gough Street Baltimore, Maryland 21231 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Holy Rosary Cemetery 02/26/2010 Baltimore, Maryland Signature of Funeral Service Lice David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final Pitysician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury rcinoma with Metastases Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes 2 ↓ 9 ☐ Unknown P.O. I signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? has h 24a. Was an page 2 autopsy performed? Ves 2 XNo certificate 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be completed filled in by the funeral director, 26. Place of Death (Check only one) မှ Other 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death Funeral Director: A 1 Tyes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the ! Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific and address of person who completed cause of death (Item 23a) (Type, Print) atri 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elfriede 4:15 PM Rigg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Wels, Austria **Funeral** 6. Sex 8. Date of Birth Dec. 14. 1 □ M 2 🗓 I Min. 1924 **Director** 213-64-1780 Usual Residence of Decedent or 28a-f shov mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland sartment of Health and Mental Hygiene.

ortant: If item 27 is marked od ther than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho ortant: If item 27 his marked od ther than "naturalic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 🗌 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 106 Oakleigh Avenue 21061 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fritz Reischel Maria Loesch FLFAME permit. Page 1 and 2 shot.
Department of Health and
Important: If item 27 is m
any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Helmut Rigg /Son 414 Rockfleet Road Lutherville Timonium MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State February 18, 2010 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. Crownsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Crmeation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) nunno Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Dav Year detached the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 🗌 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? after death. ieral Director: A filled in by the fu 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 2010 s of person who completed cause of death (Item 23a) (Type, Print) 1061

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Beverly Cortes Revnolds January 3:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10360 Blue Arrow Court Columbia Howard 5. Social Security Number Birthplace (State or Foreign Country)
 Annual Country If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 🔀 F Months June 10,1927 Director 232-58-0564 Michigan Usual Residence of Decedent or 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 10360 Blue Arrow Court U.S.A, 21044 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) College Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Ketcik Maxine Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel M. Cortes (Son) 10318 Tailcoat Way Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot Date 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2-1-2010 Glen Burnie, Maryland 21. Signature of Funeral Service License 22, Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Interval Between Onset and Death Physician/ Medical resulting in death) Due to or as a consequence of Examiner an kinjon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 signed by the attending particle by the detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖼 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 YNO Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Matural 5 Pending injury Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 22448

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State Registrar

DHMH 17 Rev 7/2009

FEB 16 2010 Sum &

Paul Gertler M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4801 Dorsey Hall Drive #226

Ellicott City, Maryland 21042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Nicholas Robey Jr. Month 7:30 A M February 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 408 Harwood Road Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Country) Maryland Hours Director 220-36-6014 68 lan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera Harwood Road 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married þ 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: white 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Nicholas Robey Margaret Mary Shiloh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hartnagel-sister 208 Rollingfield Road, Catonsville MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Elematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State Meadowridge Mem Gardens 2-15-2010 | Elkridge MD Donation 5 Other (Specify) Signatur 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Sequentially list conditions if any leading to immediate Physician/Medical Exam 2 Medical Certificate: To Be Completed

Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ned by the a certificate has b lirector, page 2 s

show

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural"

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany

Medical

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

funeral director. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

	cause. Enter Underlyin. Cause (Disease or iinjury that initiated events					
	resulting in death) Last	Due to (or as a consequence of):				
,	d.					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy er (specify)		23d. Date of de Month	elivery Day Year
	Orcavic Obsta	ributing to death but not resulting in the underly				o the cause of death? Probably 4 D Unknown
- L	Alceholism Tobacca Aby	r. Diserdor.	J	24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of s 2 X No
	25. Was case referred to medical		26. Place of Death (Chec	ck only one)		
	1 ☐ Yes 2 🕱 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [☐ DOA Other: 4 ☐ Nursing H	ome 5X Residence	6 ☐ Other (Spec	cify)
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work?	28d. Describe how inju		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street a City or Town, Stat		ral Route Number,
	(Check 2 Medical Examine)	ian: To the best of my knowledge, death occure r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	at the time, date and place	ce, and due to the	cause(s) and manner state
	29b. Signature and title of certifier		29c, License number	29d. D	ate signed (Monti	h. Dav. Year)

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ste

ZUO

405 Frederick

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Judith Rudell 05, 2010 Feb. 12:22P.^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Sunshine Acres Assisted Living Harford County White Hall If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2**X** F Days Hours 218-54-0128 58 Director Baltimore, MD 02,1951 July Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore County Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 3616 Southside Ave. Funeral 21131 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or i any Injury or other traumatic event, the Modical Example ORCE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 12 Emergency Room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving Jefferson Bradley Julia Elizabeth McKenzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Paul Edward Rudell (Husband) 3616 Southside Ave. Phoenix, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Feb.07, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Evans Funeral Chapel 2010 Forest Hill, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation have, h 2325 York Road Timonium, MD. 21093 23a. Part. But the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease disease or condition resulting in death) ! /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Dehydration 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Malnutrition autopsy perform Division of Vital 1 □Yes 2 No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSISTEN 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 □Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only within 2 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 2/5/10 me w 019914 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Fine Marjand Lu Orenville mp 10753 Falls Road 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month Rose Marie Renfrow Feb 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 712 North Woodward Essex Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In vrs. last birthday) Min. (Month, Day, Year) 1 ☐ M 2 ☐X 214-26-8836 79 **Director** 21, 1930 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 712 North Woodward Drive 21221 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Food Store 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be filed f Health and Mental Hitem 27 is marked ott John George Kalb Marie Clara Kalb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul G. Renfrow Sr./husbahd 712 North Woodward Drive Balto. MD 21221 item 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place)
Bayview Crematory 2/15/10 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livens 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or compline rations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only o Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, frany, leading to immedicause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No P Pregnant at time of death the 9 Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s nas autopsy certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 TYes 2 NO ြု To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 00067697 2-12-2010 address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nelia E. Sanchez - Crespo

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** UELYN Day Year 20 PM /Medical -66 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CONTER MEDICAL BALTIMORE MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 21540926 1 □ M 2 🗗 F Months Director OCT North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits works the Medical Examiner must be notified at MO BALTIMORE Director 1X Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? South LARELLOO ö items 23a 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any injury or other treasment. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Collection Agent Collection Agency 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Miles Hester Miles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry B. Rodgers Husband 722 S. Lakewood Avenue, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date February 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 5, 2010 Baltimore, Maryland Name and Address of Facility Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lue to (or as a consequence of): HYPER CALNEA disease or condition resulting in death) /Medical Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and burial-trar P.O. Box 68760. attending physician for use as the buris Physician/Medical DRA WENTRIC IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) the detached cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 **N**o 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERCY 31. Date filed (Month, Day, Year, 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service					-	of Facility							
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39	ath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pr	egnancy				- 4	23d. Date of	of delive	ery	
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DHMH 17 Rev 7/2009

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Director	5. Social Security Number 6. S			ore City	C O Date of Birth	n/a	idhalaaa (Otata aa Fa
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Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items. any injury or other traumatic event, the Medical Examiner muones. To Be Completed by Funer	20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Disposition (Name of the Place of Disposition (Name of the Place of the Pl	place)	Date 20/10	20c. Location - City o	
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71	30. Name and address of person who		1 23a) (Type, Print)	0.00		(
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2010 Marion Phillips Szymanski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Sparrows Point 7501 Iroquois Avenue Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/02/1934 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Min. 1 □ M 2 🕅 F Director 219-30-7015 75 Usual Residence of Decedent 28a-f shov 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location **Funeral Director** MD Baltimore Sparrows Point 10e. Street and Number 10g. Citizen of What Country? 21219 7501 Iroquois Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Ulidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Jid be filed w.r., d Mental Hygiene. --ked other than "r (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ပ Griffiths Thomas Phillips Marjorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important; If item 27 is any injury or other tra 7501 Iroquois Avenue, Baltimore, MD 21219 Richard Szymanski / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 02/15/2010 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/) moren disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 You 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month signed by the a Id be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Tes Yes To the Hospital or Attending Physician: "within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

9:20 P M

10d. Inside City Limits

MD 21076

Interval Between

Onset and Death

Day

19105, 3010

City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Year

1 🗌 Yes 2 🕱 No

Medical State

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1564

DHMH 17 Rev 7/2009

Registrar

North

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of	Marylan	d / Depa	artment of H	lealth ar	nd Mental H	Hygiene	9	0070
		State Registrar			Cei	rtificate of I	Death		Reg. No	2010	03/85
Physicia	a n	1. Decedent's Name (First, Middle	le, Last)					2. Date ofMonth	Death Da	y Year	3. Time of Death
/Medic		Leslie		Herma	n	Saund	ers S	7	-	2010	9:41 P.M
Examin	er	4a. Facility Name (If not institution	n, give street and num	ber)	21/	4b. City, Town, or				. County of Death	
		5. Social Security Number	6. Sex	7. Age (In yrs.)	Mast hirthday)	If Under 1 Year	L TIPY	ORE 4 Hrs. 8. Date of	Birth	N/A	nplace (State or Foreign
Funeral Director		216-16-1629	1 M 2 □ F	7. Age (III yis. I	Van	Months Days		Min. (Month	Day, Year) 29-19	Cot	vland
		Usual Residence of Decedent		00)			1 03-	27-17	ZI Har	yrana
how		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
e Ma	cto	MD N/	A			Balti	Lmore				1 XYes 2 No
or 28	Director	10e. Street and Number				10f. Zip Code				tizen of What Cou	intry?
be filed within 72 hours after death with the Maryland the Hydiene. Hydiene		1106 Lyndhur					1229		-	S.A.	
er de	Funeral	11. Marital Status	Armed For		S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origir an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	 Race - Amer Black, White 	
rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	e		i∐Yes 2 X INo	Specify:		1	Specify: Bla	ack
"natural";	be	15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	ation		16b. K	ind of Business/I	
in 75	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give life. I	kind of work done of DO NOT use retired	during most o d)	of working	1		
d with giene	ĕ	12th Grade	College (1-	-401 5+)	Truc	k Drive	r		Ye	llow Fi	ceight
al Hy	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (First, Mic	ldle, Maiden	Surname)	
Ment arkec	၉	Tennyson			Sa	unders	Edn	ıa	Co	sby	
of a Should be filed within 72 h d a Should be filed within 72 h d thin and Mental Hygiene. Tris marked other than "natuu traumatic event, It. In Adical		19a. Informant's Name/Relations	ship (Type. Print)			ng Address (Street			-		ip Code)
and lealth m 27 her t		Edna Saunder	s(Daughte			Lyndhu		Baltimor Date		21229 ocation - City or 1	Farra State
ges 1 If ite or ot		20a. Method of Disposition 1 Burial 2 □ Cremation	3 ☐ Removal from S	state		sition (Name of natory or other plac				_	
it. Pa rtmer rtant:		4 Donation 5 Other (5		Ga		n Fores		2/18/10		ltimore	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service	Licensee A. U.	Mellia	. J	oseph ^{ad} H	SSOUNCE FULL TO	wn Jr.	Fune	ral Hor	ne 4D 21217
		23a. Part 1. Enter the disease, o	r complications that ca	aused the death						11.17.	Approximate Interval Between
Physician		shock, or heart failure. List Immediate Cause (Final	· /		Ja	elevatic	Vas	1 D	1000	20	Onset and Death Un Lingurn
/Medical		disease or condition resulting in death)	a. Due to (c	or as a consequ		CLEVOLIC	Vasa	Mar 1-1	Jens	*	Unimoun
Examiner		Convertible list conditions	b								
₽ #	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying		ur de a euriseyi	Jenes Uf):						
and I-trans	Examiner	rany, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	sease or injury ed events n death) Last Due to (or as a consequence of):								
		resulting in death, Last	Due to (d	or as a consequ	uence of):						
	dical		d								
certifi iding se as	/Me	IF FEMALE:	23c. If yes, outo	come of pregna	incv					23d. Date of deli	ivory
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth 2 Feta	Ideath 3[☐ Ectopic pregnand ☐ Other (specify) _	;y			Month	Day Year
that the dended by the detached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unkno		0						
ires that signed b		Part II. Other significant conditi	ons contributing to de	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. [oid tobacco	use contribute to	the cause of death?
w requires been sign should be	d by	Hyper	tension					1	□Yes 2	. □ No 3 □ Pr	obably 4 Unknown
w requ	lete							24a. V	Vas an	24b. Were au	topsy findings available
The lav	Completed							_ p	utopsy erformed? es 2 2 No	death?	completion of cause of 2 No
	Ø.	25. Was case referred to medica	ıl				26. Place o	1 □ Ye of Death (Check or		o I Lites	2 21110
	.o B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nurs	sing Home 5 ☐ F	Residence	6 ☐ Other (Spec	cify)
ding Pt h. After tt funeral	n:T	27. Manner of eath 1 Natural 5 Pendir	28a. Date of	of Injury h, Day, Year)	28b. Time of	28c. Injur Wor	ry at k?	28d. Descr	ibe how inju	ry occurred	
endin eath. or: A	atic	2 ☐ Accident invest	igation				Yes 2□No	0			
or Att fter de irect n by 1	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 28e. Place buildir	of Injury - At ho ng, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office			on <i>(Str</i> eet a. Town, Stat		ıral Route Number,
oital of urs at urs at illed i	ပိ							1			
To the Hospital or Attending Physipin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		ng Physician: To the I Examiner: On the ba and mann	acie of ovamina	tion and/or in	voctigation in my	pinion dooth	h accurred at the ti	mo data an	d place, and due	to the cause/s)
To th within To th	Me	29b. Signature and title of certifie	er ~			29c. Licens	se number		29d. Da	ate signed (Monti	n, Day, Year) 2010 Tylan Fallaal
) Just	Keren	a N	0	Do	10558	79	Feb	nery 3	2010
		30. Name and address of person	who completed cause	e of death (Iten	23a) (Type,	Print)	/) 1/	10	1 /2,000
		21 Date filed Many 120 14	en JTAg	nes //u	mital	900 Cal	ton An	once 17	1/7m	ore Irlan	ry land aladi
Sta Registr		31. Date filed (Month, Day, Year,		gistiar's Signa	Rule	9-20					
negiati	uı	PER I	6 2010 2	um	a. 1	arks					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010 rica Inthony /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SY 12501 HE 1 State of Birth (Month, Day, Year, Nov. 17, 1 RIDGE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 1945 New York 100-34-1127 Director 64 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shov dical Exaπiner must be notifled at Baltimore Windsor Mill Maryland 1 ☐ Yes 2 🛣 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 United States 5607 Northgreen Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕱 No Specify: ģ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Merchandiser Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Marie Domini Anthony Sica Injury or other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Joyce Sica / Wife 5607 Northgreen Road Windsor Mill, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 15. Pages 1 Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitCremation Society of Maryland, Inc. Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ermena /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performe 1 Yes 2 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural s after decreal Director; After 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 24 hours after de e Funeral Directo letely filled in by ti Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Hospital Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Certifying Nirse Practicities. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** 9:29 PM Lillian L. Skolyak 13 FEB 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Voor 1 M 2 X F 212-40-5229 Director 68 May 7. Maryland Usual Residence of Decedent s 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5501 Catalpha Road 21214 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. event, the Medical Examinar m 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🛣 No Specify. Q Q Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Ment item 27 Is marked r other traumatic e ပ္ Frederick B. Myerly Loretta D. Schlicken- Mair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Catalpha Road, Baltimore, Maryland 21214 Benjamin J. Skolyak, Jr/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages t Department of H Important: If ite any injury or ot February 15 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston Ula Lou 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Severe sepsis /Medical Due to (or as a consequence of) Examiner Aspiration pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Disse to Cirias a consequence of Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, diabetes mellitus, hypertrophic 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown cardiomy opathy, acute on chronic renal failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide

death certificate be executed attending physician a for use as the burial-t been signed by the should be detached the pate has t certificate Hospital or Attending

Baltimore, Maryland 21215-0036

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Records,

of Vital

Division

2 should be fill and Mental F

after death Director: 124 hours a completely filled

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yadav Nandini

5601 Lochraven Blvd Baltimore MD 21239

FEB

2010

RESOU

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Pigistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red, No.

		1	For State Registrar	oraro or mar	ylaria / D	Certifica			ı	Reg. No.	0 0	03/88
Phys	siciar		1. Decedent's Name (First, Middle, Las	st)		· · ·			2. Date of Dea Month	ath Day	Year	3. Time of Death
	edica		Audrey Anne S	tone					Februar		2010	5:10 a ^M
Exa	mine	r	4a. Facility Name (If not institution, give	·		4b. Cit		r Location of Dea	th		unty of Death	
· ·			Manor Care Ross 5. Social Security Number 6. S	eville 7 Age (In yrs. last birt	hday) If Und	KOSE er 1 Year	dale If Under 24 Hrs	S. 8 Date of Birt		timore	place (State or Foreign
Fune Direct			220–14–4597	□ M 2 👫 -	-	Yrs. Months		Hours Min		1925	Mary	ntry)
land ow			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi									
Mary a-f sh	1	5	Maryland Baltim	ore	7	Notting	ham					1 □Yes 2 X No
th the	oto cito	<u> </u>	10e. Street and Number				ip Code			10g. Citizen	of What Cour	ntry?
ath wi	1 2		1 Whitelaw Place	Apt 1C			21	236	Ţ	Jnited	Stat	es
er deg items	le contra	5	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec If Yes, sp	edent of F ecify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14.	Race - Americ Black, White,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other tran matic event. The Medial Experiment than 2 and the promited at	P P	2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes	2 X No	Specify:		Spe	ecity: Whi	ite
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filed Hygi other	O O	5	17. Father's Name (First, Middle, Last)		AC	Countai	IL.	18. Mother's Na	me (First, Middle,			.tineric
rlan Jid be Jenta Red c	<u>a</u>	ם	Lawrence H. Grimm	, Sr.				Ada T.	Flaugher			
ary shou		Ī	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Addres	ss (Street		Rural Route Numbe		wn, State, Zip	Code)
and 2 and 2 salth n 27 i			Matthew A. Stone/	Husband	160	00 Ever	greer	Way Apt	t 224, Es	sex, M	farylar	nd 21221
Ore Jes 1: Jes 1			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from State	20b. Place of cemeter	Disposition (Na y, crematory or	ame of other plac		uary 15.		on - City or To	
Limor Pages tment of tant: If its			4 ☐ Donation 5 ☐ Other (Specify	y)	Metro (Cremato	ry,Ir	$\mathbf{e} = 20$	10	Baltim	nore, M	Maryland
Ball permit Depar Impor	once.		21. Signature of Funeral Service Licen	see Amanda He	aston	22. Name a	and Addre	ess of FacilityCre ick Road	emation S , Baltim	ociety ore, M	of Mar Marylan	ryland, Inc. nd 21228
		T	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	e death. Do n	·			-			Approximate Interval Between
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Box eath cer attendin for use			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3 ☐ Ectopic	nregnanc	ev.		23d.	Date of delive	
O. E he dea the at the at	Dhyeician/	5	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown		5 Other (-		Month	Day Year
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ecords, P.O. BG law requires that the death as been signed by the atter 2 should be detached for u	2	2	aren, other digital contains of	or death out in	ot resulting in	the underlying	cause giv	en in raiti.			o 3□ Prot	/
v requirements	4								24a. Was a	an 2/	1h Were auto	psy findings available
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	Ē	2	1 Yes 2 No			patient 3 🗆 🛭		4 Nursing	Home 5 ☐ Resid	lence 6	Other (Specif	у)
LIVISION OF VITA If or Attending Physician: after dealn. Frector After this certification by the funeral director, I	Certification.		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Yo	(ear) 28b. T	ime of ijury M	28c. Injur Worl	yat k? Yes 2 □No	28d. Describe h	ow injury oc	curred	
Vittern dead dead ctor	fical		2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	I	- At home, far			res 2 🗆 NO	28f. Location (S	Street and Ni	imber or Bura	al Route Number,
DIVI spital or At ours after d eral Cirect filled in by	i i		4 ☐ Homicide determined	building, etc.	Specify)	,	,,		City or Tow	n, State)	inser or riare	i riodic rumber,
Hospital 24 hours a Funeral cetely filled		-	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of ex and manner stated	camination and	, death occurre d/or investigation	d at the ti	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	d manner as s ce, and due to	stated. the cause(s)
To the Hosp within 24 ho To the Fune completely f	Mp		29b. Signature and title of certifier	and marrier states		25	9c. Licens	e number		29d. Date sjo	gned (Month,	Day, Year)
			I MAN MD	(DSA	727		2/15/	0	
		1	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type, Print)	Da -	10	bods	10	D IIA	021271
	State		31. Date filed (Month, Day, Year)	32. Regi al	8 X I S	Wal	11/10	m vv	vuas	MUCH	ex IVI	" CICSY
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 107 2010 **Physician** 03: 60 PM tokes Jebnan ne /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death Bultimore 2014 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under **Funeral** Days 259-30-1 M 2 D Months 92 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinational be notified at 10d. Inside City Limits 1 Xes 2 No Director a Himal 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 122 Was Decedent Ever in U.S. Armed Forces? 12. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Q.C 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Battimore 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Majden Surname) ould be fi STOKE Pages 1 and 2 should and Pent of Health and Men ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) 2 NOL permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once. $\pm mos$ OH 44103 veland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2016 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 4600 Libe hts Balta. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final SEPTIC SHOCK **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of):

TESA PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last STREPTUCOCCAL PHEUMONIA Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of) RENAL FAILURLE Box 68760 PHAUS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) the O á ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ VEMENTIA 1 ☐ Yes 2 ☐ 💢 3 ☐ Probably 4 ☐ Unknown Completed TIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate har ral director, page ? autopsy SHOCH performed? 1 **X** es Division of Vital 1 ☐ Yes 2 🗆 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: spital: 1 Sepatient 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 atural Injury , 5, 5, s after de_{a.} , seral Director: A' filled in by the Accident 1 🗆 Yes 2 \square No ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 24 hours a Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie within 24 hor To the Fune completely f (Check only one) 29b, Signatur 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type_Print)

723746

aton Ave. Bul timore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 12 16a 19a per fb g901 3-15-10 vt

State of Maryland Department of Health and Mental Hygiene vt State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Charles David Scott 2. Date of Death 3. Time of Death Physician/ ebruan 22 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OWSOr Itimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 229-16-1573A 1 M 2 F Days Months Hours Min. (Month, Day, Director Usual Residence of Decedent should be filed within 12 inc.
I and Mental Hygiere.
I is marked other than "natural", or items 23a or 28a-1 sinov.
I is marked other than "addical Examiner must be notified at or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Hmore JWUNT 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1950-\$ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. 1952 Black 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Engineer (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) မှ Cott les 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other fram Scott-Wife 10 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mills torest VA)WINGS **E**ITTISON 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Home Baito 2120 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe shock, or heart failure. List only one cause on each line Immediate Cause (Final Opset and Death Physician/ disease or condition resulting in death) neumoni Medical Due to (or as a consequence of): Examiner ement Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical nding p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ atter for u in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year the. 9 Unknown To the Hospital or Attending Physician: The law requires that the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performe this certificate 2 No Yes 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ္ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manger of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 🗌 No Accident Investigation Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68104 address of person who completed cause of death (Item 23a) (Type, Print) N. Charles State Registrar

DHMH 17 Rev 7/2009

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PURCELL SELLERS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CROSS MOWHERMER If Under 1 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Year 1 . M 2 X F Months Hours Min 3 **Director** Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DN+GOMER 1x Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 tment of Health and Mental Hygiene. tant: If item 27 is marked other than 'jury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) EESTAURANT OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RUDOLF WALKER PURCELL BELVEDERE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H Important: If it any injury or o once. 🛮 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State SILVER SPRING MP 4 ☐ Donation 5 ☐ Other (Specify) Signature of Foneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death INFARTION Physician/ MYO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? rmed? 2 **K** No 1 ☐ Yes 2 🛣 No Yes To the Hospital or Attending Physician: within 4 hours after der th.

To the Funeral Director After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 🐒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pagica ButuaM.D 50678 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/20 New Hampshire Ave Silver Spring, MD Batra Kaleev

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month P

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VERNON STEELBERG NO /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. **X** M 2 □ F 91 219-01-9179 10,1918 Aug. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🙀 No Baltimore County Directo Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 4015 Putty Hill Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify. 3√Widowed 4 ☐ Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) B.G.& E. Mechanic permit. Pages 1 and 2 should be flied or Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be John William Steelberg Alice Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Wyland Ct. Leland . N.C. 28451 George Steelberg (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 2~18~2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses LÂSSAHN Address (Facility 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner nal fibrillati Sequentially list conditions, if any, leaving to infractional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Completed by Physician/Medical as the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be rector, page 2 s autopsy 1☐ Yes 2 No 1 ☐ Yes 2 □ No or Attending Physician: funeral director, Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Man er of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury To the Flustria.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

SHAPPIDERG, V.

DHMH 17 Rev 1/2001

State Registrar VASILIADEI, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Minus Vasiliades, 9000 Franklin Sc

D0064755

Square Drive, Baltimore MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JEANETTE W. STURM 2010 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PICKERSGILL, INC. TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Min. 1 M 2 X F **Director** 213-16-9964 10/26/1921 MARYT, AND Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f MD BALTIMORE TOWSON 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a o Funeral 615 CHESTNUT AVENUE 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 X Married Completed by Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BILING CLERK 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med BLUE CROSS & BLUE Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE SHIELD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ of Health and Ment f item 27 is marked other traumatic e NICHOLAS MACKOWSKI SABINA SASADEUZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID STURM/SON 1323 DALTON ROAD BALTIMORE. MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ò = 5 💢 Burial 2 🗌 Cremation 3 🗎 Removal from State cemetery, crematory or other place)
GARRISON FOREST VET. Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 2/25/2010 21. Signatur of Funeral Service Licensee MO1119 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. LOCH RAVEN BLVD. TOWSON. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ a 12010 Medical Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Due to (or as a consequence on attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Live to the lime of death in the past 12 months? Day Year ours after death. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2-2 No 2 🗌 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide injury work? 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signa 2079544 30. Name and address of person who completed gauge of death (Item 23a) (Type, Print) 652 CHARLES ST. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10a & 19b per Fh g900 2/22/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 805 **Physician** 2010 rera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Basto 1801 Wentworth Genesis Paning 6128 Parkway Center imore Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 MARYLAND Social Security Number 6. Sex **Funeral** Months Days Hours Min. 216-03-1960 1 □ M 2 🗆 🗲 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madient Experiment and the notified at once. 1 ☐ Yes 2X No Director MD BALTIMORE PARKVILLE 10e. Street and Number
Hiss
3135 HILL AVENUE 10f. Zip Code 10g. Citizen of What Country? 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐**X**Vo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No If Yes, Give Year or Dates Specify. 2 Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY TRUCKING 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ JOHN WILLIAM JUNG VERNA MAY KELLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3135 HILL AVENUE BALTIMORE, MD 21234 19a. Informant's Name/Relationship (Type. Print) DIANNE MCDONALD/NIECE Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEM. PARK 2/16/2010 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) me and Address of FacilityTHE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO217 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rogressor disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Box 68760. Joint Discens Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 □Yes 2 No Month Year P.O. the detached 9 Unknown cate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Mi 30 Wheens 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 □ Yes 2 🖽 🗸 6 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Funeral Directo etely filled in by ti 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MD D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. ELITAW ST SHIE 308 BACTIMORE MD 21201 HASHMI 82 A MD 32. Registrar's Signature State Registrar

Timothy Speaman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 8, 2010 **Medical Examiner** 2330 hrs pearmar 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1000 North Collington Avenue **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) Foreign Director Country) Mary laved 214-68-332 1 M Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 No other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. IA Homore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ne 01122 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: þ r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 uaver nt of Health and Mental Hygiene.
t: If item 27 is marked other the other traumatic event, the Med 17. Father's Name (First_Middle, Last) 18. Mother's Name (First, Middle, Pages 1 and 2 should be filed Be searman TNITA Dearma Informant's Name/Relationship (Type, Print) ဥ (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANITa Dearman Kavenwood Battimore 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page
Department of
Important:
injury or oth xattimore arnes Donation 5 Other Specify: 21. Signature of Funeral Service 22. Name and Address of Facility Howell tuneral 4600 - Liberty Home Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Morphine intoxiction complicated by hypothermia Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and tran Physician/Medical AMENDED 23a,27,28a-f,permE, X UNPENDED the attending physician ned for use as the burial g900 2/25/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 s death? performed? this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗹 Other Scene 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Director: 1 Yes 2 X No 5 Pending within 24 hours after death. To the Funeral Director; Fd 2/8/10 unk Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1000 blk. Collingtor 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide 6 X Could not be found on street (Specify) Homicide Baltimore, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 9, 2010 39 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32 Registrar's Signatur State C FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year LLOYD JOHN SHIPP anuali 2010 4a. Facility, Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ARUNDE Buenie BALLIMORE Washington GLEN ANNE Medical Center If Under 1 Year | If Under 24 Hrs. Social Security Number Sex → 1 M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Days 218-46-0098 64 01/12/1946 Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7770 Old House Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fire Elementary/Secondary (0-12) College (1-4or 5+) Captain <u>Investigation</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Shipp Lillian Mock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Dove / Niece <u>2907 Gladnor Road, Pasadena, MD</u> 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02/01/10 Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Foreral Service Licensee 169 Riviera Drive, Pasadena, MD 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ■No 24a. Was an autopsy performed? Yes 2 Who 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated re and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Sign

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s after dea... ral Director: Aftr To the Hospital within 24 hours a To the Funeral I the Hospital

Physician

/Medical

Examiner

Funeral

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Important: If any Injury or once.

Physician /Medical Examiner

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Completed by

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Certification: To

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30. Name and address of per ARA 31. Date filed (Month, Day,

State Registrar

DHMH 17 Rev 1/2001

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mar	•	epartment of		Mental Hy	giene	
			State Registrar			Certificate o	f Death		Reg. No.	1 03797
н	Physicia	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day Year	3. Time of Death
-	/Medic		William	SKIPPE	R			FEBRU		
	Examin	er	4a. Facility Name (If not institution, give	1.	C-521/E	2.	, or Location of Death	h C	4c. County of De	/
40.00			NORTHWEST 7 5. Social Security Number 6, 8	10001111	In yrs. last birt	/ / / /	ar If Under 24 Hrs.	8. Date of Bir	BALL-0	rthplace (State or Foreign
н	Funeral Director		-	1 7 5 7 5 7 5 7 5 7 5 7 5 7 5 7 5 7 5 7	•	Yrs. Months Day		09-12-	v. Year)	nnsylvania
			Usual Residence of Decedent		,					
	rylan ihow	_	10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits
	e Ma	cto	MD Carroll			Sykesville	!			1 □Yes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
	s 23a	ıal	6506 Ridenour Wa				784		United St	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Experience question of the death.	Funeral	11. Marital Status1 ☐ Never Married 2 ☒ Married	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No	1957	If Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puert	pecity yes or No to Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1961	1 □Yes 2 🛣 N	lo Specify:		Specify: W	hite
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pq	be file ntal Hy ad oth event	Be (17. Father's Name (First, Middle, Last)			ŀ		, Maiden Surname)	
yla	should band Men s marker umatic	မ	John Skipper					abeth 0'		
Maryland	0 0 10		19a. Informant's Name/Relationship			•			er, City or Town, State,	
	1 and Health em 27 ther to	1	Doris M. Skipper	- wile				Date	Sykesville, 20c. Location - City of	
altimore,	Pages nent of h int: If ite iry or of	į	1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (Name of y, crematory or other p			,	,
亞	it. Partment		4 ☐ Donation 5 ☐ Other (Special 21. Signature — uneral Service Like		rleadowr				Elkridge,	
Ba	permit. Departr Importa any Inji		21. Signature in uneral service tice	Brohau	ı			-		ral Home at ge, MD 21075
П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do r	not enter the mode of	dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	core	NHIZL	ARTER	Les DiSE	ASE		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence	of):				
	Examine	<u>_</u>	Sequentially list conditions,	b	and the same of th					
	ted sit	nine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a r	sonsequence o	ot).				
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	consequence (of):				
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687	ificate g physis the	edic		d						
Box	Attending Physician: The law requires that the death certific ar death. **rdoath.** After this certificate has been signed by the attending pertor. After this certificate has been signed by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of d	elivery
<u> </u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregna 5 ☐ Other (specify			Month	Day Year
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Vita	ysician: The is certificate h director, page	Be	25. Was case referred to medical examiner?	Hoopital.	,			ath (Check only o	one)	
of	Phys this (은	1 ☐ Yes 2 ☐ No 27. Mann, of Death	Hospital: 1		tpatient 3 1 DOA			dence 6 Other (S)	pecify)
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isi	Attend death. ctor: / y the fi	ficat	3 ☐ Suicide 6 ☐ Could not b	e 290 Place of Injury	- At home, fai	rm, street, factory, offic		28f. Location (Street and Number or	Bural Boute Number
Division of	after after Direction by	Certification: T	4 Homicide determined	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)	Taran Trouto Marinosi,
	To the Hospital or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the	1		nysician: To the best of						
	he Ho in 24 he Fu pletel	Medical	(Check only 2☐ Medical Exa	on the basis of e and manner state	xamination an d.	id/or investigation, in m	y opinion, death occi	urred at the time,	date and place, and d	ue to the cause(s)
_	Vith To t	Σ	29b. Signature and title of certifier	De O	_	29c. Lice	ense number		29d. Date signed (Mod	nth, Day, Year)
			,	Xhm J	luj) 1	14502	-	TEBRUATE	8, 2010
	12V		30. Name and address of person who	^ -	th (Item 23a) ((Type, Print)	Nontr	TWETT	465017	te Contin
			31. Date filed (Month, Day, Year)	0 WA W A W 32. Registrar's	Signature		PANIAL	STOWN	, whorey!	AND 2119:
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			Bed ov Cuiv	Land la	17					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For	Plea				nd / Dep	artment	of H	łealth		All Copi Mental H		_	ble.	
	State Registrar 1. Decedent's Name (Fi	irst, Middle	, Last)			Ce	rtificate	of E	Death		2. Date of D	Reg. N	No. 20	10	3. Time of Death
n/ al.	James	Albe	ert S	chmitt							Month Februa		_• 201	Year .0	10:00 A
	4a. Facility Name (if not			,			4b. City, To					4	4c. County o		
4	The Sanctu 5. Social Security Numb		6. Sex	7. Ag		ast birthday)	If Under 1	Year	nsvi] [fUnder	24 Hrs.	8. Date of E	irth	Montg	9. Birt	hplace (State or Fore
	324-24-836		X X ^{M 2}		83	Yrs.	Months	Days	Hours	Min.	July 2	ay, Year	1926 Country linois		
- 1	Usual Residence of Dec 10a. State 10	b. County			10c. Cit	y, Town or L	ocation						· <u>-</u>		10d. Inside City Lim
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Py	1 Never Married	2 \square Marr	ied 1	ped Forces?	No		If Yes, specify Cuban, Mexican, Puerto Ri			Rican, etc.)		Black	Race - American Indian, Black, White, etc.		
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completed	(Specify	only highe	t's Education st grade com	pleted)	F\	(Give	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)						.Kind of Bus ited S		
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0 0	17. Father's Name <i>(First, Middle, Last)</i> Bernard F. Schmitt						18. Mother's Name (First, Middle, Maiden Surname)								
ŀ	19a. Informant's Name/			nt)		19h Mail	na Address (S	Street			J. C1 al Route Numl			ate Zin	Codel
	Katherine			•	ghter		-				e Laur			. ,	
	20a. Method of Disposit		3 Remov	al from State	20b. F		osition (Name matory or oth		e)		Date	20c.	Location - C	City or	Town, State
1	4 Donation 5	Other (S	pecify)	ai iioiii Otate	Gat		Heaven				2010			pri	ng, MD
	21. Signature of Funera	DService L	censee	_	/M00	2770					Home,			.1	- 20707
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1	resulting in death) Due to (or as a consequence of):														
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nataidilloo												opsy formed?	de	ior to c ath? Yes	completion of cause
	25. Was case referred to examiner?	medical						26. Pla	ace of Dea	th (Check		-2×	NOT I		250
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				building, et							City or To				
Medical	(Check 2 🔲 I	Medical E	kaminer: On	the basis of	examination	n and/or inves	tigation, in my	opinio	n, death o	ocurred at		and place	ce, and due to	o the c	ause(s) and manner s
	only one) 3 🗌 0 29b. Signature and title		Nurse Pract	ioner: To the	best of my	y knowledge,			time, date	and plac	e, and due to		e(s) and manr Date signed (i		
			w	=			0	00	54	566	,	2	181		
;	30. Name and address of						Print)								
	Subjection	BON	gavil	Ma	Soi C	unair	ANNU	1 1	1-17	- 538	verson	ina	MAN	17	0902.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day , Physician/ Month February 2010 4:00 PM George Lester Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severn 8360 Timberlake Court If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** ^{Year)}19<u>38</u> 1 🖾 M 2 🗆 F Days Hours Min. Month, Day, Ye July 16, Virginia Yrs Director 227-52-7806 71 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21144 U.S.A. 8360 Timberlake Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. ρ 1 Never Married 2 X Married "natural", or 1 Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Black 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other Rosa Lee Doc Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8360 Timberlake Court, Severn, Maryland 21144 Gladys Smith Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) New Hope Bapt. Ch.Cem 2/13/2010 4 ☐ Donation 5 ☐ Other (Specify) New Canton, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. bollit 3 Talbott Ave. , Maryland 20707-4389 M00773 Laurel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ facture Concestive weart disease or condition month Medical resulting in death) Due to (or as a consequence of): **Examiner** Meas Cardionyapath Sequentially list conditions, Examine Due to for each persequence of: cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Diabetes 42015 mellit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 d. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Yes Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown +ransplant Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 2 No Yes 2 No 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🖳 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical | 1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

32. Registrar's Sigrature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Steven Zemel

D2(22)

808 Landmark Drive, Glen Burnie, Maryland

2/9/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2:45 PM 2010 JOSEPH Ε. SCOTT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death Examiner 2 Minner If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 XM 2 ☐ F 244-68-5272 Director 11/2/1943 NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maclical Evantinar must be notified at Director XXYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 4648 PARK HEIGHTS AVENUE 21215 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1XX Never Married 2 Married 1 ☐ Yes 2XXNo Specify. þ Specify Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, in a 1945 once. Elementary/Secondary (0-12) College (1-4or 5+) HVAC MECHANIC HVAÇ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JEREMIAH SCOTT RUTH BOYD 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD SCOTT/BROTHER 3518 GRANITE RD. WOODSTOCK, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State BALTIMORE CREM.CNTR. 2-12-2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition resulting in death) **Physician** | dalk /Medical Due to (or as a consequence of): Examiner 15 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical the attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I □Yes 2 □No o 9 Unknown signed by I be detach 23e. Did tobacco use contribute to the cause of death? hipbuting to death but not resulting in the underlying cause given in Part I. Records, Completed by icate has been si , page 2 should t 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? certificate Vital 2 No tansion 1 □ Yes director, Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To of this funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010

State Registrar 30. Name and address of person M

31. Date filed (Mon

Known As: Joseph Suct

atient

o completed cause of death (Item 23a) (Type, Print)

1407018567

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Feb. Day Ellen Deby Schindler 9 2010 9:55 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8 Date of Birth (Month, Day, Months Hours Min. 1 M 2 F Country) Director 92 214-26-8334 191 JulyUsual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2X No Timonium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 12103 Tullamore Ct. Unit 101 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: white Completed 3X Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Ludloff James Batchlor permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8204 Carrbridge Circle, Towson, MD 21204 Joseph Schindler/grandson 20a. Method of Disposition 1 Sp Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/16/90 Dulaney Valley Memorial Gardens Timonium, MD Donation 5 - Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W Padonia Rd., Timonium, MD 21093 Funeral Service Lice Inc. 23a. Part 1. En er the lisease, or complications that caus shock, or heart fa ure. List only one cause on each I ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate (ause (Fin) Physician brovas disease or condition resulting in Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): as the burial-transit and Due to (or as a consequence of): resulting in death) Last aftending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 Who
9 Unknown Day within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 2 DNo Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injuly occurred 1 Natural work? 5 Pending injury 2 🗆 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 🖄 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifler (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70110. Bush 31. Date filed Month, Day, Year) 32. Registrar's Signature

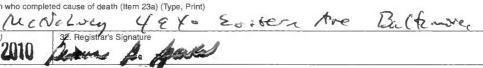
State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death __Month Year **Physician** 0940A Fes Lewis Charles Schmidt 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Esther's Place Assisted Living Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. S*e*x 1**X** M 2□ F Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 91 Yrs. 216-01-6458 December 24, 1918 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 1XXYes 2 ☐ No Director MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 2802 Pinewood Avenue 21214 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Ma Once. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Employee Food Service 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Schmidt Anna Richter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cotton - Friend 3615 Advocate Hill Drive, Jannettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evens Funeral Chapel & Cremation Services- Parkville 23a. Part.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WEEK neumania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ atrial CANCER 1 ☐ Yes 2 Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an autopsy performed' 1 □ Yes 2 □ 100 Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 \sum Nursing Home 5 \subseteq Residence 6 to ther (Specify) Estherly 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Doath 28b. Time of PIACE 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation Asses s after death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide ò 29a, Certifier 1 🗗 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2-57e-D42127 weather

State Registrar

31. Date filed (Month, Day, Year) FEB 16 2010



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State o	of Mai	ryland	•	artment of h			nental Hy	gien Reg. N	711	0	03803
Physicia	an	1. Decedent's Name (First, Mid									2. Date of De Month		ay	Year	3. Time of Death
/Medic		Colleer			ipl	еу					FEb.	2	20	010	2354 M
Examin	er	4a. Facility Name (If not institut				1.	160	4b. City, Town, o	or Location	of Death		4	c. County of		
		5. Social Security Number	6. S			CON.	st birthday)	If Under 1 Year	541/504 if Under	24 Hrs.	8 Date of Bi	rth		O Birth	place (State or Foreign
Funeral Director		214-30-5880		M ≱EMF	/. Age	73	Yrs.	Months Days	Hours	Min.	8. Date of Bi	ay, Yea	36	Cour	value (State of Poreign
		Usual Residence of Decedent										,	<u> </u>		
rylan how	_	10a. State 10b. Coun	•			10c. City,	Town or Lo							1	0d. Inside City Limits
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th with the Marylan 23a or 28a-f show ust be notified at	Director	10e. Street and Number			3			10f. Zip Code	. 1 1			10g. C	citizen of W	hat Cour	ntry?
ath w	ral	40 Beaco)[] .					218					USA		
be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'm Madical Examiner must be notified at	by Funeral	11. Marital Status1 ☐ Never Married 2 ☐ Ma3 ☒Widowed 4 ☐ Divorce		12. Was Dec Armed Fe 1 □ Yes If Yes, G Year or D	orces? 2 📉 No ive		- 1	Was Decedent of Market Pes, specify Cub			ecify Yes or No Rican, etc.)	0-		, White,	ean Indian, etc. ite
be filed within 72 hours ital Hygiene. id other than "natural" event, the Mydical Ex.	Completed	15. Deced (Specify only high Elementary/Secondary (0-12)	nest gra	ducation ade completed) College (1-4or 5+		(Give life.	dent's Usual Occu kind of work done DO NOT use retire	durina mos	st of work	ing		Kind of Bus		dustry
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permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni any injury or other traumatic event, the Mutal Once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specif	fy)	State	l cer	netery, crer .y Tr	inity C	emet	ery	2/9/1	0	Elkr	idge	e MD
Depar mpor any in		21. Signature of Fineral Service	e Licer	nsee	11	0	22	2. Name and Addre		50					to. MD
		23a. Par 1. Enter the dis ase.	Ly	Comme	4	bo dooth	Do not an						of	Ess	ex 21221
		23a. Par 1. Enter the discase, shock, or heart failure. Li Immediate Cause (Final	nly	one cause on	eac line	ne death.	Do not en					arrest,			Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a	4	100	wary	artes	40	l. je	ore			_	Years
Examiner				Due to	(or as a	conseque	ence of): /								
	je	Sequentially list conditions, if any, leading to immediate	J	b Due to	(or as a	conseque	ence of):								
e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	1	C.											
e exe ian ar irial-ti		resulting in death) Last	ı		(or as a	conseque	ence of):								
ate be ey hysician the burial	lical		-	d											
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth 2 nant at t	f pregnand □ Fetal o ime of dea	death 3	Ectopic pregnand Other (specify)	су				23d. Date Mor		ery Day Year
that ned by deta	V Ph	Part II. Other significant condi	tions o	contributing to c	leath but	not result	ing in the u	nderlying cause giv	ven in Part	l.	23e. Did	tobacco	use contri	ibute to ti	he cause of death?
w requires that the d been signed by the should be detached	d by										10	Yes	2 🗌 No	3 Prof	sably 4 ☐ Unknown
s bee	Completed										24a. Was	an	24b. W	Vere auto	ppsy findings available
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sician; The la certificate ha irector, page 2	a l	25. Was case referred to medic	al						26. Place	e of Deat	1 ☐ Yes h (Check only	<u> </u>	10 1	□Yes	2 🗆 140
nysic nis ce direc	To B	examiner? 1 ∐ Yes 2. X No		Hospital: 1	Inpatien	t 2	R/Outpatie	nt 3 DOA Oth	ner: 4 🗆 N	ursing Ho	ome 5 ☐ Res	idence	6 □Othe	er (Specil	fy)
ng Pl		27. Manner of Death 1 Natural 5 ☐ Pend	lina	28a. Date (Mor	of Injury	Year) 2	28b. Time o Injury	28c. Inju Wor	ry at rk?		28d. Describe	how inj	ury occurre	ed	
tendi eath. or: A	Certification:	2 Accident inves	tigation			-]Yes 2□	No					
or Att	Ě		mined	28e. Place	of Injur	y - At hom (Specify)	ne, farm, str	eet, factory, office			28f. Location City or To	(Street a wn, Sta	and Numbe ite)	er or Rura	al Route Number,
pital o		200 Cartifier 4 Counti	Di	uniala . T. Ab				h		and the			(-) l		
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medic	al Exar	miner: On the I	e best of casis of e nner state	examinatio	ledge, deat on and/or in	h occurred at the t vestigation, in my	opinion, de	nd place, ath occur	, and due to the red at the time	, date a	nd place, a	ind due to	o the cause(s)
7 vit	-	29b. Signature and title of certif		0 1	1	1.		29c, Licens		3			ate signed		
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60		30. Name and address of person	AC		se ot dea	auri (item 2	LANA PANA	Poll Ct	50	1 h.	1012 0	10	215	en.	
Stat	te	31. Date filed (Month, Day, Year			Registrar	's Signatu	re	VLL 31:	W/7/	ISOU	rig !	·ce	~10	UI	
Registra		PPD 1 4 4044	1	115		1-									
MH 17 Rev 1/20	001	FR 1 6 5010 V	Row	we p	. 14	Day L									
							ORIG	INAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TERRY SLOUGH rebruary 1200 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE VA HEDICAL BALTIMORE CEMTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**x** M 2 □ F Hours (Month, Day, Year) an 27, 1940 Country) Director 269-36-7473 Ohio Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4821 Attenborough Way 21043 United States 'natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: Specify: 3 Divorced White Completed Year or Dates. 1957-77 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Soldier U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic Eckhardt Slough Marjorie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda J. Slough/wife 4821 Attenborough Way Ellicott City, Maryland 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 2/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Sign wre of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 phys the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Veal P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tyes P 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 KNatural 5 \square Pending work? 2 No ☐ Accident ☐ Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Mile 29c. License number

Registrar

X

mo

GREENE

completed cause of death (Item 23a) (Type, Print)

MORTH

10

THOMPSUN

722955

STREET

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 28 2010 0738 Ŏ 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samanon 9. Birthplace (State or Foreign If Under 8. Date of Birth Social Security Number 7. Age (In yrs, last birthday) **Funeral** Min. (Month, Day, Yea Months Hours 1 **№** M 2 🗆 F 3 Yrs. -92-215 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f shrongortant: If item 27 is marked outher than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 236 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: SIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bovernmen Vr5 any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mem, tark 4 Donation 5 Other (Specify) Kina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 300 STIVE Sequentially list conditions, Due to for as a consequence offiif any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 1 death? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 🗓 🛚 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) and title of certifier 29b. Sian NINE, 2010

State Registrar 30. Name and address of person who complete

FEB

latricia

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Loch Raven Blvd, Baltimore,

Md

21239

cause of death (Item 23a) (Type, Print)

5601

32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Schloecler, Mary 2-13-16 0030

Baltimore, Maryland 21215-0036

			Plea	ase Type or Pr State of M	laryland / D	Depa	artment of I	Health a		•		•	ble.		
			Registrar 1. Decedent's Name (First, Middle	e. Last)		Cer	tificate of I	Death		2. Date of De	Reg. No	20	10	3. Time of Death) 7
	Physicia Medic		Mary	Catherine			Schroed	er		Month Februa		3, 20	Year 010	12:30 A	ν _M
, min.	Examir		4a. Facility Name (if not institution Gilchrist Hospi				4b. City, Town, o		of Death		40	o.County o Baltir			
	Funeral Director		5. Social Security Number 214-16-6420	6. Sex 7. A	ge (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da October	rth a <i>y, Year)</i> 22 ,	1921	Country	ce (State or Fore yland	ign
	and show 1 at	ror	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	eation						10	d. Inside City Lim	its
	Maryl 28a-f otifie	Director	Maryland Balti	more	Du	nda								1 🗌 Yes 2 🗖	No
	with the s 23a or ust be r	Funeral D	10e. Street and Number 103 Center Place	ce Apt 233			10f. Zip Code 21	222			10g. Ci	itizen of Wi USA	nat Countr	y?	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. If Health sand Mental hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	If Van Chia	?	l If	Vas Decedent of H Yes, specify Cub:	an, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)		14. Race Black Specify:	White, et	0.	
15-0	72 hour matu edical	plet		nt's Education est grade completed)	1	(Give k	ent's Usual Occup	during mos	t of worki	ng	16b. K	Kind of Bus	iness Indu	stry	
212	within giene.		Elementary/Seconday (0-12) 12 years	College (1-4 or	5+)		o NOT use retired) usewife	,				Own	Home	!	
Maryland 21215-0036	e filed ital Hyg ed oth event,	To Be	17. Father's Name (First, Middle, I				-	1		(First, Middle Nona S					
aryle	should be fill and Mental is marked of		Clyde Ellis Tak 19a. Informant's Name/Relations		19b.	Mailin	g Address (Street	l					te, Zip Co		
	nd 2 stealth a m 27 is		Susan Williams	Daughte			Dunbar R	oad,	Dunda	alk,Mar			1222		
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2, any injury or other t		20a. Method of Disposition 1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (\$	Specify)	_ cemeter	y, crem awn	sition (Name of natory or other pla Cemeter	У	Febr	2010	Dur	ocation - C ndalk	,Mary		_
Baj	permit Depar Impor any in		21. Signature of Funeral Service I	Licensee Cont. M	e lles	22 C	Name and Address Onnelly 110 Soll	Funer Funer	al H	ome Of	Dunc	dalk,	P.A.	1222	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lir	ed the death. Done ne.	ot ente								Approximate nterval Between Onset and Death	
90	te be executed nysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	s a consequence o										
. Box 68760	The law requires that the death certificate be or it is at the has been signed by the attending physicis page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 MoNo 9 ☐ Unknown		2 Fetal death at time of death		Ectopic pregnan Other (specify)	су				23d. Date Mont		/ day Year	
ls, P.O.	law requires that the de has been signed by the i je 2 should be detached		Part II. Other significant condition	ons contributing to death	but not resulting in	n the u	nderlying cause g	iven in Part	l.				_	cause of death?	wn
Division of Vital Records,	The law req cate has bee page 2 sho	Completed by								24a. Was auto perf 1 Yes	opsy ormed?	pr de	ere autops for to cometh? Yes 2	y findings availab pletion of cause o	le of
lita	sician: certific irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	*i 2 \(\pi \) FP/Ov		- Oth	Place of Dea				. 1	<i>o</i> ::	20/0600	<u>_</u>
n of V	ding Phy h. After this funeral d	sate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of inj (Month, D		ime of njury	28c. Inju	ry at	. :	me 5 Res 28d. Describe		1		HOSPICE	2
Divisio	To the Hospital or Attending Physician: The la within E14 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	2 ^f Accident Investi 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e. Place of In	jury - At home, far tc. <i>(Specify)</i>	m, stre			_	28f. Location (City or To	(Street an wn, State	nd Number e)	or Rural F	oute Number,	
	he Hospii in 24 hour he Funera	Medical	(Check 2/ Medical I	Physician: To the best of Examiner: On the basis of Nurse Practioner: To th	examination and/or	r invest	igation, in my opini	ion, death o	ccurred at	the time, date	and place	e, and due t	o the caus	e(s) and manner s	tated.
	To the within 2 To the comple		29b. Signature and title of certifie				29c. Licens	se number	120		29d. Da	ate signed	Month, Da	ay, Year)	
	6.		30. Name and address of person	who completed cause of	death (Item 23a) (Гуре, Р	rint)	7 60	7	/	7 6	<u>-110</u>	126) (C)	í
	り√ Sta	to-	Eric Bush 1 31. Date filed (Month, Day, Year)	n) 670 A	LCharl rar's Signature	ec	St, S	>u1fe	041	05/	alf	imo	e N	10 2120	1
	Sta Registr		EER 1 6 2010	<i>A</i>	A Las	23	1			1			ę		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 11, 2010 Physician 10:15 P M Bertha Μ. Shea /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Collingswood Nursing Center if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 6, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F 96 213-44-2737 1913 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Kensington Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 United States 3408 Murdock Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No White If Yes, Give Year or Dates: Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Registered Nurse Nursing and Mental Hygies marked other t event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nt of Health and Ments t: If item 27 is marked r or other traumatic e Mary Kish George Matthews ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3408 Murdock Road, Kensington, Maryland 20895 Denise Shea / Daughter altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date February 15, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Bethesda, Maryland Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 le toel The M01305 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine for use as the burial-trans resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mont 1 □Yes 2 X No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Advanced Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \(Yes \) 2 \(\Delta \) No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed director, this funeral ours after death.
seral Director: Ai
filled in by the fu within 24 hours a completely the

Medical Certification: To

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

State Registrar

Sayed Elsayyad, DO 31. Date filed (Month, Day, Year) FEB 1 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 ☐ Could not be

determined

10110 Molecular Drive, Rockville, Maryland 20850 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0062435

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death redent's Name (First Middle | ast) 2 Date of Death SCHINDLEN Physician/ F GB 08:00P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOMERFORD PLACE ASSISTED LIVING COLUMBIA HOWARD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 🕱 F Days 0476871929 80 Yrs. 217-26-0948 **Director** MD Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No MD HOWARD COLUMBIA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8220 SNOWDEN RIVER PARKWAY 21045 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Yes 2 No Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **ABRAMS** SARA **ABRAMS** HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. RICHARD SCHINDLER / HUSBAND RIDGE RD., UNIT C601. ELLICOTT CITY.MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/09/2010 | BALTIMORE, MD BNAI ISRAEL CONG. 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD. PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ NEUMONIA disease or condition resulting in death) Medical to (or as a consequence of) Examiner SMENTIA Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown signed by t Pa<u>t</u> II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate 1 Tes To the Hospital or Attending Physician: 'within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital မှ 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 0700

of person who completed cause of death (Item 23a) (Type, Print)

Signature and title of certifier

29c. License number

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30 per dvr g900 2-16-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Donald JUHTON 2010 11.15 05 -4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death PRINCE GEORGE'S FORESTVILLE FORESTVILLE HEALTH & REHAB 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5 (1471 97)5 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days Hours Min CHEVERLY, MD **X**□ M 2□ F 34 215**-**94-7801 Usual Residence of Decedent PRINCE GEORGE'S 10c. City, Town or Location NEW CARROLLTON 10d. Inside City Limits MD1 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 7759 RIVERDALE RD #203 20784 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ No Specify: SpecifBLACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN SUTTON LAVERNE BODDIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078419a. Informant's Name/Relationship (Type. Print) LAVERNE SUTTON/MOTHER 7759 RIVERDALE RD #203 NEW CARROLLTON, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) CHESAPEAKE CREM. : 2/11/2010 BELTSVILLE, MD 21. Signatur 9 Funeral Service Licen 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., DC 20002 23a. Part 1. Enter the disease shock, or heart failure. I e, or complications that caused the death. Do co enter the mode of dying, such as cardiac or respiratory arrest, Li t o ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 mmun Lesion Sequentially list conditions, if any leading to imposite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? rt II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4

Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed by

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id other than "natural", or Items 23a or 28a-f show event, the Modest Eventing Tust by milling at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any lnjury or other traumatic event, I'm. Mede once.

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Baltimore, Maryland 21215-0036

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Sertification: To	27.
dical C	29
Me	29

1 Yes 2 No Manner of Death 1 X Natural

Was case referred to medical examiner?

2 Accident 3 Suicide 4 Homicide

29b. Signature

6 ☐ Could not be

29a. Certifier

31. Date filed (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 1) 51520

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

02-08-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad 9900 Rustic Rail Lane Vienna, Va. 22181

State Registrar

determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EBMOHUMARY Day 4 Year 1 Physician/ The 1 ma Ε. Seagle Medical 4a. Facility. Name (if not institution, give street and number) 4b. City, Town, or Location of Beath 4c. County of Death timore **Examiner** Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1arch 27 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. Country) Maryland 1 🗆 M 2 💢 F **Director** 217-12-6062 March 28a-f show 10d, Inside City Limits at 10a, State 10b. County 10c. City. Town or Location Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Lutherville <u>Maryland</u> <u>Baltimore</u> 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral within 72 hours after death with 21093 U.S.A. 204 Rothwell Drive items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. , or 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: "natural" Completed 3 X Widowed 4 Divorced White Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Antique Dealer Antique Business Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Wilson Leslie Edler Elizabeth V. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 19a. Informant's Name/Relationship (Type, Print) 16912 Oueen Anne Bridge Road Mitchellville, Susan Lonergan Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

Signature of Fulfaral Violationsee Hilltop Service Corp. 2-16-2010 Towson Maryland ature of Fuliera 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Sig Inc. 21204 Wiga VO 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST Pnysician/ disease or condition Medical resulting in death) CUTE MYUCARDIAL INFARCTION **Examiner** Sequentially list conditions Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Pregnant at time of death I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RESPIRATORY FAILURE 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has performed? Yes 2 No 1 Yes 2 No director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 LOW. M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 6 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 4 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EMenthUARYDay 13. 2011 Physician/ 3:33P Robert John Sievers Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center owson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, Funeral Days 1**X**☐ M 2 ☐ F Hours Min. CountryColorado 8/16/1927 521-30-0056 82 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21286 919 Beaverbank Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14 Bace - American Indian. vvas Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XX No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired)

Publication Editor (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) News Media 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William O. Sievers Elizabeth O'Neill Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21286 Kathleen M. Sievers / Wife 919 Beaverbank Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/18/2010 Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility TOWSON, Maryland 21204 21. Signature of Funeral Service Lic Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA Medical resulting in death) Due to (or as a consequence of): **Examiner** DAYS ACUTE RENAL FAILURE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Directo (or as a nonsequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed 1 ☐ Yes 2 🕱 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier DØØ63974 Gall

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State 31. Date filed (Month, Day, Year)
Registrar

SB 1 6 2010 Linux J. Jank

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SNELL JANUARY 6:00 PM 31 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TURE CARE BALTIMORE 040 COURT RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🙀 F Director 213-12-0309 Oct 28, 1913 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2015 Wisper Woods Way 21244 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Andreal Experiment any Injury or other traumatic event, the Andreal Experiment 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Howard Susan Howard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Wisper Woods Way Windsor Mill, Maryland 21244 Michael Snell 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/09/10 Elkridge, Md. Meadowridge Memorial Park 21. Signature of Funerath Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Lectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I I Inknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been s e 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. the Hospital within 24 I

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Dan

MARSON P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

1838 GREENE TRUE ROAD #300 FILESVILLE MO 21208

29d. Date signed (Month, Day, Year)

2010

 $^{\rm Amend}~\#17~{\rm per}~{\rm Fh}~{\rm g}901~3/9/10~{\rm TT}$ Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	l / Departm	ent of He	alth and Me	ental Hygien

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				1- For State Certificate of Death Reg. No.	No.
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vie	edica	I Exam	mer	Debra Ann Tipton Sebruary 14, 2010 0606 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
-				Upper Chesapeake Medical Center Bel Air Harford	
		uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign	_
	D	irector		220.48.3747 1 M 2 F 48 Yrs. 03.31.1961 Country MD	
		any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi	its
	-	*	_	MD 11-6-1	
)	ac lone	daryland 28a-f show Latonce,	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	_
	, MD 21215-0036 and 2 should be filed within 72 hours ofter death with the Mondand	dearn with the Maryland or items 23a or 28a-f sho must be notified at once,	ä	1205 Joppa Road 21085 U.S.A.	
	de saviete	ems 2: t be no	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
	ar deat	or dear , or ite r musi	[문	I Yes 2 No	
	de sa	urs arr tural" amine	d b	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
	3	/2 no m "ma al Ex	etec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
	003	eu witnin /z nours ar tygiene. other than "natural h. M.dical Examin	Completed	2 Owner/Self Employed Domestics	
	21215-0036	should be riled with and Mental Hygiene. ?7 is marked other tl natic event, the Med	Be C	Thomas William Tipton Thomas William Tipton Thomas William Tipton Thomas William Tipton Thomas Tipton	
	212	Mental I marked c event,	To B	Thomas William Tipton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_
	MD	th and N 1 27 is n umatic		Raven Radel/Daughter 1205 Joppa Road, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
	Ē,	of Health If item		1 Burial 2 Cremation 3 Removal from State crematory or other place)	
	Baltimore,	Department of Health Important: If item 2 injury or other traur		Chesapeake Crem 02.19.10 Beltsville, MD	
	Balt	Department Important: injury or ot		21. Signature of Funeral Service Licensee Molyy3 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, F 8717 Green Pastures Dr. Balto., MD 2128	7A 36
		ysician		23a. Part l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interv	
4		ledical aminer		Immediate Cause (Final disease a. Complication of acute mycardial infarction Death	_
•				h Atherosclerotic cardiovascular disease	
			ner	Sequentially list conditions, b. At ITETOSCIETOCIC CATGLOVASCULAT GISEASE If any, leading to immediate Due to (o. as a consequence of).	_
1			Examine	C) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
A	position	and transi		d. V	
'	760,	ysician and burial - transit	Medical	X AMENDED #17 Per FH G901 3/03/2010 JH #17 Per FH G901 3/05/2010 PI line a-b, PII,27,permE, g901 3/1/10 TT	
		the ph		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 tive high 2 Fetal death 3 Fetapic pregnancy Month Pay Year	
	9 X	attending for use as t	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
	. Box	ned by the a detached fo	Physician	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	_
	ivision of Vital Records, P.O. Box 68	gned b	by	Hypertension 1 Yes 2 No 3 Probably 4 VUnknown	1
	ds,	s been si should b	Completed	24a. Was an 24b. Were autopsy findings availab	
	of Vital Records,	cate has	ldmo	autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	i
	<u> </u>	certificate		25. Was case referred to medical 26.Place of Death (Check only one)	_
	Vite	this co	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:	
	n of	eath. or; After t		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
	Division and or Attendit	r death ector: by the	cati	2 Accident Investigation 28e Place of Injury At home form street factory office building etc. 29f Location (Street and Number of Bural Bosto Number City	+1.
	Divi	ours afte	Certification:	Suicide 6 Could not be determined (Specify) Suicide 6 Could not be determined (Specify)	y
()	Cothe Hosnits	24 h Fun etely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	_
100/	WA S	within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
Y			100	O.C.M.E. February 15, 2010	
				30. Name and address of person who completed cause of death (Item 23a)	_
				Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
		S Regis	tate	31. Date filed (Month, Day Year) 32. Registrate Signature 1	

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month O2 4:54 PM arran 2010 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** tymore ou ylan . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days (Month, Day, Months Min. 60 Yrs. MARYLAND Director <u>214-54-7329</u> 1950 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No N/A BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral U.S.A. 1204 N PARRISH ST 21217 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 X Never Married 2 ☐ Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) KEYSTONE PHARMACY PHARMY TECH ASSISTANT 12th grade any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) COLIA LAMPKIN EDWARD TARRANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1044 Vine St., Baltimore, Maryland 21223 Domonique M. Tarrant/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND Metro Crematory 02-15-10 Signat ure of Funeral Service Licensee Name and Address of Facility COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. mediate Cause (Final Physician/ Sep 515

Due to (dras a consequence of): disease or condition resulting in death) Medical Examiner letastatic Cance Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) /sician and 9 burial-transit Exami death certificate be executed mong that initiated events resulting in death) Last Due to (or as a consequence of): ending physician ruse as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year 5 Other (specify) Pregnant at time of death signed by the a g 🗌 Unknown P.0. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 N his certificate h 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work thours after death.

Uneral Director: Afted filled in by the fun 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 95250457

State Registrar 31. Date filed (Month, Day

S. Greene

rson who completed cause of death (Item 23a) (Type, Print)

32. Registra Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	f Marylan	•	rtment of H <i>tificate of L</i>			001	0 00017
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	leg. No.	3. Time of Death
	Physici /Medio		LEROY TURNER SR.					Month FEB	Day Yea	ar -7:00 A
- m	Examin		4a. Facility Name (If not institution, give street and nu	mber)		4b. City, Town or	Location of Death		4c. County of D	eath
de la				SICE		Di	=/CAM	0	HARA	-ORS
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day	(, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	8.	1			DEC. 14	1928 F	LORIDA
	how	_	10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits
	Ba-f s	Director	MARYLAND HARFORD CO			HAVRE D	E GRACE			1 ☐ Yes 2 🕅 No
	vith th		10e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dicel Examinar must be notified at	Funeral	421 ROCK RUN PLACE	edent Ever in U.S	S 13 W	21078		pecify Ves or No-	U.S.A.	merican Indian,
(0	fter d	표	Armed Fo	orces? 2X No	1	as Decedent of Hi Yes, specify Cuba		Rican, etc.)	Black, W	
21215-0036	ral",o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Gi Year or D	ve ates:	1	□Yes 2 X OXNo	Specify:		Specify:BL	ACK
5-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occupa	lurina most of work	king I	16b. Kind of Busine	ss/Industry
121	within ene. than '	m	Elementary/Secondary (0-12) College (1	I-4or 5+)		O NOT use retired			III(DED I	ALD HAMD THA
р 5	filed v Hygie		17. Father's Name (First, Middle, Last)		LABC	OR_SUPERV		e (First, Middle, i	LUMBEK I Maiden Surname)	NDUSTRIES
<u>a</u> n	lid be fental ked c	To Be	DAVID TURNER					E HAYWOO	·	
ary	shou and A s mai		19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	g Address (Street a			r, City or Town, State	e, Zip Code)
Σ,	and		Leroy Turner Jr./Son						Florida 3	
altimore, Maryland	Pages 1 nent of H ant; If itel ary or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		lace of Dispos emetery, cremi	ition (Name of atory or other place	e)	Date	20c. Location - City	or Town, State
<u>=</u>	# 본번증	l l	4☐Donation 5 ☐Other (Specify)			EMETERY	02-2			, MARYLAND
Ba	permi Depa Impo any ir once.		21. Signature of Fungfal Service Ligenson		WM 32	I C BROWN	COMMUNI ADELPHIA	TY FUNER BLVD.,	AL HOME-H ABERDEEN,	ARFORD, P.A. MD 21001
Н			23a Part 1. Enter the disease, of complications that of shock, or heart failure. List only one cause on e	aused the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)) VITTE	5 chr	miz of	14 sort vi	re Pulm	many DDEC	Onset and Death
J'	/Medical Examiner		Due to	(or as a consequ				·		
		er	Sequentially list conditions, if any, leading to immediate	or as a consequ	rence of).					1
	cuted od ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	e exe sian ar urial-t			(or as a consequ	uence of):					
58760,	icate be executed physician and the burial-transit	edical	d							
9 X	leath certific attending p for use as f	/Me	IF FEMALE: 23c. If yes, out	tcome of pregnar	ncv				23d. Date of	dolivory
Box	death e atter d for u	Physician/M	1 Ves 2 No 4 Pregi	birth 2 ☐ Fetal nant at time of de		Ectopic pregnancy Other (specify)	<i>'</i>		Month	Day Year
0.0	t the by the acher	hys	9 ☐ Unknown 9 ☐ Unkn	own						
Ś.	w requires that the described by the should be detached	by P	Part II. Other significant conditions contributing to de	eath but not resu	Ilting in the und	derlying cause give	en in Part I.			e to the cause of death?
Records,	een s	ted	Mostal & co	rncer				1/83 Y	es 2 No 3	Probably 4 Unknown
Sec.	e law l has b je 2 st	Completed	hypert	envin	\			24a. Was a autops	sy prior	autopsy findings available to completion of cause of
ā	n: The icate							perform 1 □ Yes	med? death 2 ⊠No 1 □ Y	n? ′es 2□No
Vital	siciar certif	Be	25. Was case referred to medical examiner? Hospital:			Othe	26. Place of Deat			
ō	ding Physician: The h. After this certificate h funeral director, page	n:To	27. Manner of Death 28a. Date	Inpatient 2 ☐ I	28b. Time of	28c. Injury Work	4 La Nursing H		ence 6 Other (S	pecify)
0	ath. rr: Aft	atio	1 Natural 5 Pending (Mon: 2 Accident investigation	th, Day, Year)	Injury		? ∕es 2□No			
Division of	al or Attending Physician: The law requires that the death certificate be executed safter death. I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit d.	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of Injury - At horng, etc. (Specify	me, farm, stree	et, factory, office		28f. Location (Si City or Town		Rural Route Number,
1	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 dedical Examiner: On the band man	asis of examinat	wledge, death tion and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the o	cause(s) and manner late and place, and o	r as stated. due to the cause(s)
	o the vithin ; o the omple	Med	29b. Signature and title of certifier	ner stated.		29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)
	F>F0		· De la M	m v	hn	D.	27975	-	2/8/10	
	31		30. Name and address of person who completed caus	e of death (Item	23a) (Type, P	rint)			010110	
	J*		DAVID MCCLUPY 1	515 Ma	nc Plail	nd Be	1 Am.	MP. 2	4014	
	Sta Registra	te ar	31. Date fire Brit Day 2010 Leven	egistrar's Signat	garla	nd Be				

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 14,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Peath **Examiner** CHUCIIS 70SP, 5. Social Security Number Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1**X** M 2□ F 215-70-6004 Director 05-04-1958 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner must be notified an once. Director MD N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 21225 3511 3rd Street U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/a 10th Grade Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence R. Novella Thomas James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Novella Thomas (Mother) 3511 3rd street, Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 02/18/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Tisysters OI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. 6 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation illed in by the fi 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical

and manner stated.

a-12

30. Name and address of person who completed cause of death/(Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

14,2010

1 XYes 2 ☐ No

Maryland

State Registrar DHMH 17 Rev 1/2001 29b. Signature and Tie

31. Date filed (Mont

eleh

thuest itoipil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ame (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death N/A Season's Hospice Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/09/1922 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🛣 F Months Days Hours Min. Director 218-22-4767 87 Usual Residence of Decedent 10a. State 10b. County 10c, City. Town or Location 28a-f show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, Inc. Mcdical Exert in a must be notified at 1 XYes 2 No Director N/ABaltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2207 Monticello Road Funeral 21216 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: within 72 hours after 1 Never Married 2 Married 2 should be filed within 72 hours aften and Mental Hygiene.

is marked other than "natural", or it Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: <u>გ</u> Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2years Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Martin Roberts Sarah Perrv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r Shelia Thompson(Daughter) 2207 Monticello Rd., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. 2/16/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD any 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and -trar attending physician a for use as the burial-Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22thNo 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Seath 28b. Time of After 28c. Injury at Work? 28d. Describe how injury Hospital or Attending 5 Pending investigation 1 Natural 2 Accident death. I hours after death. uneral Director: A ely filled in by the fu 1 □ Yes 2 □ No ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 To the 29b. Signature and 29c. License number

P.O. Division of Vital Records,

> State Registrar

30. Name

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 11, 2010 **Physician** CARL SHERMAN **TSCHANTRE** 9:25 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3213 CALVERT STREET BALTIMORE CITY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 221-20-0832 6/18/1934 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Microal Examiner must be neithed at 10a. State 1X Yes 2 □ No Director MD N/A BALTIMORE CITY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 Funeral 3213 CALVERT STREET USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 😿 No Specify Specify: þ WHITE 3 Widowed 4 Divorced 1956 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medione." Elementary/Secondary (0-12) College (1-4or 5+) OFFICE SUPPLIES OFFICE MANAGER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARNOLD J. TSCHANTRE LILLIAN SHERMAN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SEVERNA PARK, MD 21146 6 LINSTEAD RD. KENNETH H. TSCHANTRE/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 2/16/2010 | CATONSVILLE, MD 21. Signatury of Funeral Service Licensee MO1189 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Typcardia Physician /Medical Due to or as a consequence of): Examiner therosclerosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 1 ☐ Yes 2 DNo certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Aesidence 6 ☐ Other (Specify) 2 ANO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours are dear To the Funeral Cirector completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23a) Type, Rrint) address of person who comp

State

Registrar

TRICLI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ chuary 2010 Toatley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctor's Community Hospital Prince George's Lanham 7. Age (In yrs. last birthday) Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 X M 2 □ F Hours July 23, Year 1968 New York Director 41 115-66-9717 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6021 Springhill Drive 20770 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 2 💢 No 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Station Manager Metro Bus Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Toatley Blanch Pulley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Freeman (Sister) 231-10 125th Ave., Queens, NY 11413 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Nassau Knolls Port Washington, NY 22. Name and Address of Facility
Rosedale Funeral Home
130-02 Liberty Ave., . Sign dure of Juneral Service Lice vee Richmond, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Linesa. 2. Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2. No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year)

Registrar

State

8118 GOOD LUCK ROAD, LANHAM, MD

pleted cause of death (Item 23a) (Type, Print)

32. Registrar'

M. CASTRO, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Preston Tracey 2017 752 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HIMOR 8. Date of Birth (Month, Day, 14 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days 213-46-0997 Hours Baltimore, MD. **Director** Yrs. . 1946 63 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Baltimore 1 Tes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 3725 Bay Drive 21220 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas and Elementary/Seconday (0-12) College (1-4 or 5+) Service Technician Electric N/AImportant: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard D. Tracey G. Elizabeth Stifler Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maria D. Tracey (wife) 3725 Bay Drive Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Timonium, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility Feaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List onlytene cause on each lin. Approximate Interval Betw Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi signed by the attending physician and defached for use as the burial-trar that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 morths?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 → Rrobably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 Yes 2 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ Other: 1 🗌 Inpatient 2 🕰 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident 2 🗌 No after death Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 [3 [within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) Type 32; Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of IV	-	epartment o Ce <i>rtificate o</i>		Mental Hy	giene Reg. No. 2	nin	03823
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	land show dat	ţō	10a. State 10b. County		10c. City, Town	or Location				10	Od. Inside City Limits
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lan	should and N is ma auma	100	19a. Informant's Name/Relations	nip (Type, Print) (Wif	e) 19b. 1	Mailing Address (Stre	et and Number or Ru	ral Route Numbe	r, City or To	wn, State, Zip Co	ode)
	and 2: Health tem 27		Mrs. Marianne (Nee Sgroi)Ta		06 Shelle	y Road T	owson, 1			
Baltimore,	Page 1 nent of I ant: If it		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery,	Disposition (Name of crematory or other parts) Funeral Ch	l Conce	dary		tion - City or Tov >st Hill	vn, State , Maryland
altii	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service L				ress of Facility Liternatives	2010			· -
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E			23a. Part 1. Inter the disease, or shock, or hear failure. List Immediate Cause (Final	complications that caused only one cause on each line			ying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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8760	tificate ing phy e as th		IF FEMALE:								
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n of	Attending Physician: r death. ector: After this certific by the funeral director,	Certificate:	27. Manner of Death Natural 5 Pendin		ry 28b. Tin , Year) inju	iry wo	ury at ork? □ Yes 2 □ No	28d. Describe h	ow injury oc	curred	`
Division	Atten er deat ector: by the	rtific	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	not be 28e. Place of Inju	ıry - At home, farm	, street, factory, office		28f. Location (S	treet and Nu	umber or Rural F	Route Number,
Θį	Hospital or 24 hours afte Funeral Directed filled in I			building, etc				City or Tow			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical E	Physician: To the best of xaminer: On the basis of ea Nurse Practioner: To the	xamination and/or is	nvestigation, in my opi	nion, death occurred a	at the time, date a	nd place and	d due to the caus	e(s) and manner stated
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			• Ma	WW.		De	78305		Felsa	vary 9	2010
			30. Name and address of person v	who completed cause of di	eath (Item 23a) (Type 670)	pe, Print)	LLS ST	DM 30	JyW	MD	
	Stat Registra	e	31. Date filed (Month, Day, Year)		r's Signature)					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year 25 AM ar 2010 02 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death tonsville atonss. 1/e -OMMOUS Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year)
12 26 **Funeral** Birthplace Country) (State or Foreign 1 M 2 □ F Months Days Hours Min. 283176 Director 215 79 MD Usual Residence of Decedent with the Maryland 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exprainer roust be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6203 Hopeton Ave 21215 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If lean 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examination and Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4or 5+) Pastor Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental F Important: if item 27 is marked or any injury or other traumatic ever once. James Tucker ပ Rosena Westley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Tucker-Wife 6203 Hopeton Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 2/22/10 4☐Ponation 5 ☐ Other (Specify) Owings Mills, 21. Signature of Funeral Service Licenses March For Horse 4300 Wabash Ave, Baltimore, md21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) +das /Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached Yes 2 No 9 Unknown 9 ☐ Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed Yes 2 No 2 🗆 No 1 ☐ Yes Physician: director, 25. Was case referent edical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 MNo After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. l Director: / 2 Accident 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide To the Hospital hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nem

State Registrar 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

FEB 16 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 9, Laura Terzi February Anne 12:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1928 Denbury Drive Baltimore Dundalk 8. Date of Birth (Month, Day, Year) July 17,1964 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 212-98-0120 Maryland 45 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1928 Denbury Drive 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates þ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Handicapped Recreation 10 years Volunteer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Charles Terzi Sr. Dolores E. Impallaria 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores & Joseph Terzi 1928 Denbury Drive, Dundalk, Maryland Parents 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 17, 2010 Dundalk, Maryland 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death shock, or heart failure ust only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma **Physician** Metastatic Small B /Medical Due to (or as a consequence of) Examiner Se, enably list nooding if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as ettending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 I No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 1∐ Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital

State Registrar

Medical

29a. Certifier

29b. Signature

(Check or one)

nd title of certifier

31. Date filed (Month, Day, Year) 82. Registrar's Signature

80. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Min (In D.) 9114 Philadelphia Eat 208; Baltimore, mD 21237

M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D45390

29d. Date signed (Month, Day, Year)

February

9th. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				/laryland / Dep	partment of I	Health and	Mental Hy	giene		
			State Registrar	Ce	ertificate of l	Death		Reg. No. 2	03826	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	_	,		Date of Dea Month		3. Time of Death	
	Medic	al	Anna Marie		uber		Februa	ry 9, 2010	6:00 P M	
	Examin	er	4a. Facility Name (if not institution, give street and number)			r Location of Dear	th	4c. County of Death Baltimore		
	Funeral		Gilchrist Hospice Center 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		Towson If Under 24 Hrs	8. Date of Birt		irthplace (State or Foreign	
	Director		216-30-7052 1 D M 2 🗓 F	76 Yrs.	Months Days	Hours Min		7 1934 Man	ountry) rvland	
	, MC		Usual Residence of Decedent				TOCHTALY	7,1334 144	Lyland	
	yland -f sh ed at	ctor	10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits	
	e Ma r 28a notifi	Director	Maryland Baltimore 10e. Street and Number	Dun	dalk				1 ☐ Yes 2 🕅 No	
	Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at	rall	1803 Jackson Road		10f. Zip Code	1222		10g. Citizen of What C	ountry?	
	eath v tems er mu	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Am	erican Indian	
စ္တ	fter de , or it	by	1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 🖟	No No	If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, Whi	te, etc.	
21215-0036	ursatural" In Exa	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2X No	Specify:	_	Specify: Wh	ite	
5	72 hc n "na ledio	nple	15. Decedent's Education (Specify only highest grade completed)	i (Give	edent's Usual Occup kind of work done	durina most of wo	rking	16b. Kind of Business	s Industry	
7	/ithin iene. rr thau	ပ်	Elementary/Seconday (0-12) College (1-4 or 12 years	5+)	DO NOT use retired) cretary			St. Jude S	Shrine	
D	iled v if Hyg othe vent,	Be	17. Father's Name (First, Middle, Last)		Crctary	18. Mother's Na	me (First, Middle,		эптие	
Maryland	d be f denta arked itic e	욘	Adolph Buechner			Antoine	tte Neje	dlik		
an	should n and Me rs mar raumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street	and Number or Ru	ıral Route Numbei	; City or Town, State, Z	ip Code)	
	and 2 Health em 27 ther tr		Louis Tauber Husba	nd 1803	Jackson :	Road, Du	ndalk,Ma	ryland 212	222	
or E	Page 1 a ment of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		ematory or other place		uary	20c. Location - City o	·	
Baltimore,	it. Pag rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify)	1	Faith Cemet			Rosedale,		
g	permit. Pag Departmen Important: any injury o		21. Signature of Funeral Service Licensee	elly "	Connelly 7110 Soll	Funeral ers Poin	Home Of t Road,	Dundalk,P./ Dundalk,Md.	A. 21222	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	d the death. Do hot en	ter the mode of dyin	g, such as cardia	or respiratory arr	est,	Approximate Interval Between	
-4	Physician/		Immediate Cause (Final disease or condition	ntic ce	mcc UI	VCC/121	nizin	resty	Onset and Death	
	Medical Examiner			a consequence of):			V	- 20	7	
		ē	Sequentially list conditions, if any leading to immediate	a consequence of:						
	ted ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	I or Attending Physician: The law requires that the death certificate be executed after death. Director After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial-transit	EX	that initiated events resulting in death) Last Due to (or as	a consequence of):						
20	te be nysicia ne bui	edical	d							
	rtifica ing ph		IF FEMALE:							
POX	ath ce	Physician/M		2 Fetal death 3		;y		23d. Date of de Month		
ň	the a	ıysic	1 🗆 Yes 2 🕅 No 4 🗀 Pregnant 9 🗇 Unknown	at time of death 5	Other (specify)			Month	Day Year	
J.	that the	by Pr	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
S,	n sign	q pe					1 🗆 Y	es 2 □ No 3 □ F	Probably 4 DUnknown	
ecords,	w req	plet					24a. Was a		itopsy findings available	
ě	The la ate ha	Completed					autop: perfor	med? death?	completion of cause of	
VItal	stan: artifica		25. Was case referred to medical examiner?		26. Pl	ace of Death (Che		2/4/10/	5 2 110	
5	hysic his ce	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpat	ient 2 🗆 ER/Outpatie		er: 4 Nursing F	lome 5 Reside	ence 6 Other (Spec	city) Noselle	
101	ling P	Certificate:	27. Manner of Death 1 2 Natural 5 Pending 28a. Date of injuty (Month, Death)	ury 28b. Time o iy, Year) injury	work	?	28d. Describe ho	w injury occurred		
<u>0</u>	deatl deatl ctor.	ţį.	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	ury - At home, farm, str		Yes 2 No	005 11 (0)		4B 4 44 4	
UNISION	al or A s after I Direct		4 Homicide determined 286. Place of In building, et	c. (Specify)	reet, ractory, onice		City or Town	reet and Number or Ru n, State)	rai Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of Check	my knowledge, death	occured at the time,	, date and place, a	and due to the cau	se(s) and manner as sta	ated.	
	the L		only one) 3 Certifying Nurse Practioner: To the	best of my knowledge,	death occurred at the	e time, date and pla	ace, and due to the	cause(s) and manner as	stated.	
	7. ⊻ 6 8		255. Signature and title of certifier		29c. License	number 920	2 ء	9d. Date signed (Monti	h, Day, Year) 9 2010	
			30. Name and address of person who completed cause of c	leath (Item 23a) (Time	Print\	3000)	10,000	1 2 - 10	
) 1		ARON O CHAMIES	1 M) 6	- 1	Charl	72 c	MOCHOT N	10	
	State Registra	- 1	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	7					
	negistra	•	LIBUAU CUIU COMPANDA	. sparre						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Michael Tully February 9:24 A M 11Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 ፟ M 2 ☐ F 8. Date of Birth Month, Day, Year, April 3, 1934 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Pennsylvania 079-26-2917 75 **Director** Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iom 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 🔀 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7305 Honeywell Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian "natural", or iter idical Examiner Armed Forces?

1 X Yes 2 No Korea
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates. Vietnam is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Veterans Affairs President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James George Tully Margaret Foenar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne V. Tully/Wife 7305 Honeywell Lane, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of February 2010 20c. Location - City or Town, State 14, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State injury or Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses Chase, Inc. Tur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Pnysician/ 050 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: 1116 tar together within 24 hours after death.

To the Funeral Director: After this certificate has been to the Funeral Director; After this certificate has been to the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident 1 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 and title of 29b. Sig 29d. Date signed (Month, Day, Year) mergency 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bar 8600 Bethesda George town MA old

DHMH 17 Rev 7/2009

State Registrar ton

James

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03828 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20 10 Joan R. Tittsworth 9:23 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 □ M 2 ⋤ F Months Days Hours Min. Country) Marvland **Director** 212-28-4877 78 March Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 🗆 Yes 2 😾 No Md. Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 236 Shipping Creek Drive 21666 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married "natural", or 1 ☐ Yes 2 🔀No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic mone". Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Nelson <u>Thomas J. Roache</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 236 Shipping Creek Dr. Stevensville, Md. 21666 Mr. William Tittsworth, Jr./ Hus 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 2-15-10 Towson, Md. Towson, Maryland 21204 21. Signature of Funeral Servi & Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death myourdal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Joan Tittsworth the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 4 ☐ Pregnant a 9 ☐ Unknown ed by the a detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed in director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 🗷 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural iniury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defitying righting ri (Check only one) 29c, License number 037016 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Attendous 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St., Sate 4104 Balthon, mp 21204 IDV Kenneth M. Greeke, MO

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Baltimore, Maryland 21215-0036

) /N
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	T
Division of Vital Records, P.O. Box 68760,	ne Hospital or Attending Physician: The law requires that the death certificate be executed and hours offer death
Vita	sician:
of	Phy
Division	he Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A 2407 ROSLYN AVE. BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min. 1 💢 M 2 🗆 F Director 2-13-1942 MARYLAND 218-36-5593 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Exeminar must be notified at 1 X Yes 2 □ No Completed by Funeral Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or any Injury or other traumatic event 21216 USA 2407 ROSLYN AVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 HNo Specify. Specify: BLACK 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEAT CUTTER BROWNS SUPERMARKET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLLETE E. WILLIAMS ပ HENRY THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2407 ROSLYN AVE. BALTIMORE, MARYLAND 21216 ELLA L. ZHOMAS (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ₺ Cremation 3 Removal from State 5 □Other (Specify) 2-20-2010 BALTIMORE, MARYLAND 4 Donation KING MEMORIAL PARK D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. PLicence ONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pa. 1. Firter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final dise se of condition resulting in death) **Physician** ledical Due to (or as a consequence of): aminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) as been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a Date of Injury 28h Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title who completed cause of death (Item 23a) (Typ State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

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		State Registrar				C	ertificate of	Death		Reg. No.	2010	0.3830
Physic	ian	1. Decedent's N	Name (First, Midd	fle, Last)					2. Date of D	eath Day	/ Year	3. Time of Death
/Med			·			en Thwr	eat			-	, 2010	12:10P ^M
Exami	ner	Lorien Nursing & Rehab Cent					4b. City, Town, o			4c. County of Death		
	7	5. Social Securi				ter-Columbia (In yrs. last birthda		If Under 24 I	olumbia Hrs. 18 Date of B	lirth	ward	
Funeral Director			96-8767	1 M 2 F		Yrs.	Months Days		lin. (Month, L		1	hplace (State or Foreign untry)
70		Usual Residence	ce of Decedent			86			мау	16, 192	3	Virginia
arylar show	-	10a. State	10b. County	/		10c. City, Town or						10d. Inside City Limits
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show life! Exwinite must be notified at	Funeral Director	Maryland		N/A				altimore				1 🔀 Yes 2 🗆 No
with t	ij	10e. Street and					10f. Zip Code	21225		10g. Citi	izen of What Co	-
leath wi	era	11. Marital State	arles Road	12. Was D	Decedent E	verin U.S. 1:	R Was Decedent of	21225 Hispanic Origin	7 (Specify Yes or N	10-	U.S.	
ffer d	F		us Married 2□ Mai	Armed	Forces? s 2 No	0	B. Was Decedent of If Yes, specify Cub		uerto Rican, etc.)		Black, White	
5-0036 72 hours aft natural", or	ρ	^	ed 4 Divorced	If Yes, Year o	Give X or Dates:		1 □ Yes 2 🙀 No	Specify:			Specify:	Black
5-0 72 hc natur	Completed	(5		nt's Education est grade complete	ed)		cedent's Usual Occu ve kind of work done		working	16b. Ki	ind of Business/	Industry
2121; the Med	ď		Secondary (0-12)		e (1-4or 5+	life	. DO NOT use retire	d)	working		Not Em	ploved
d 2.	ပ္ပ		me (First, Middle,	l act)			D	sabled	Name (First, Middi	la Maidan		
and d be f ental sed of	Be c	17. Faule Siva		David Ivev				To. Motriers		ice Joh	,	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machal Expriner must be notified at	ပ္	19a. Informant	's Name/Relations			19b. Ma	iling Address (Stree	and Number of				Zin Code)
re, Ma 1 and 2 s Health a tem 27 is	1	_	ce Langford				St. Charles S					
or He		20a. Method of	Disposition			20b. Place of Dis	position (Name of ematory or other pla	1	Date		ocation - City or	Town, State
Page Page ment ant: If			2 GCremation on 5 ☐ Other (5	3 □ Removal fro Specify)	om State		tro Crematory.		01/29/10	(Catonsville,	Marvland
Baltimore, permit. Pages 1 am D partment of Heal Important: If item 2 amy injury or other) H	of Funeral Service	m 2	A.		22. Name and Addre	ess of Facility Frothers Fu	neral Service	. P. A.		
52 (18)		23a. Part 1. Ent	ter the ds ase, o	r complications that only one cause o	at caused t	he death. Do not e	1300 E	utaw Place ng, such as car	Paltimore, N diac or respiratory	ld 2121 arrest,	7	Approximate Interval Between
Physician		Immediate Cau	use (Final	tonly one cause o	n eaun iine	NEMI	ENTIA					Onset and Death
/Medical		resulting in dea	ath)	Due	to (or as a	consequence of):						
Examiner	L	Sequentially lis	t conditions.	b								
ed sit	Examiner	Sequentially list if any, leading to cause. Enter U Cause (Disease	o immediate Inderlying	Due	to (or as a	consequence of):						
ob, be executed sian and urial-transit	хап	that initiated every resulting in dea	ents	c	to (or as a	consequence of):						
68760, fificate be executed a physician and is the burial-transit					10 (01 00 0	3,1304,001,00						
687(tifficate ag physi as the k	edic			d								
of Vital Records, P.O. Box 6876 Physician: The law requires that the death certificate b r this certificate has been signed by the attending physic rail director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was dece	dent pregnant	23c. If yes,							23d. Date of deli	ivery
death	icia		t 12 months?	4 □ Pr	regnant at t		B □ Ectopic pregnand □ Other (specify) _	cy			Month	Day Year
ds, P.O. res that the de signed by the a	hys	9 Unkno		9 🗆 1	nknown							
S, les the igned be de	by F	Part II. Other si	gnificant conditi	ons contributing to	o death but	not resulting in the	underlying cause give	en in Part I.				the cause of death?
Records, he law requires the has been signe age 2 should be considered.				-			· ·		1 [Yes 2[□ No 3□ Pr	obably 4 Onknown
law ras b	Completed						·		24a. Wa	s an opsy		topsy findings available completion of cause of
The law cate has page 2 s	S								per 1 □ Yes	formed? 2 N o	death? 1 ☐ Yes	2 🗆 No
Vital F slcian: Th s certificate irector, pag	Be	examiner?	eferred to medica	Hospital:				26. Place of i	Death (Check only	one)		
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r en	tion	1 Natural 2 □ Accider	5 Pendir		fonth, Day,	Year) Injury	Wor	k? Yes 2 □ No	28d. Describe	e now injur	y occurred	
Division If or Attending after death. Director: After	fica	3 ☐ Suicide	6 □Could	not be 28e. Pla	ace of Injur	y - At home, farm, s	street, factory, office		28f. Location	(Street an	d Number or Ru	ıral Route Number,
Divisio	Certification:	4 Homicio	de determ	bu	uilding, etc.	(Specify)				òwn, State,		,
Hospit Hospit Punera tely filli	Medical C	29a. Certifier (Check only one)	1 Certifyii 2 Medical	Examiner: On the	the best of e basis of e nanner state	examination and/or	ath occurred at the t investigation, in my	ime, date and popinion, death o	lace, and due to the	e cause(s) e, date and) and manner as I place, and due	s stated. to the cause(s)
To the within 2 To the comple	Me	29b. Signature	and title of certifie				29c. Licens	se number		29d. Dat	te signed (Month	n, Day, Year)
		1	provele	2			Do	06012	5 0	JAn	WARY .	29.2-01 m
		30. Name and a	address of person	who completed ca	ause of dea	ath (Item 23a) (Type	e, Print)		ا ا		' '	29,2010 25,M)
		PANKA	I THE	TE PPA			LYMBLPHI	A RD	77200	, BA	MINON	25, M)
Sta		31. Date filed (Å		32	2. Registrar	's Signature						1
Regist		-	EB 16 20	JIU B		A. Mille						

			for State Registrar	State of Ma	•	Certificate of			Reg. No.2 0 0	03831		
	Physicia		1. Decedent's Name (First, Middle, Las MARGARET MA	RY UI	RSO			2. Date of Dea Month FEBRUA	Day Year	3. Time of Death 8:55A M		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Deat		4c. County of Dea	th		
	Funeral	1	Social Security Number 6. S		(In yrs. last birth		If Under 24 Hrs	(Month, Day	h 9. Bir y, Year) C	thplace (State or Foreign ountry)		
P	Director		Usual Residence of Decedent	X				4-11-	1932 MAI	RYLAND		
	farylan f show	ō	10a. State 10b. County MD BALT	IMORE	10c. City, Town		SEDALE			10d. Inside City Limits 1 ☐ Yes 3€ No		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evan Inc. must be notified at	Direct	10e. Street and Number	IMORE		10f. Zip Code			10g. Citizen of What C			
		eral	7909 RIVERDALE	AVENUE 12. Was Decedent E	ver in LLS		21237	Specify Yes or No-	U.S.A.			
0000	ours after de ral", or item Evan incr	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes ※ Armed Forces? 1 ☐ Yes, Give Year or Dates:		13. Was Decedent of If Yes, specity Cul 1 ☐ Yes 2 ☐ No		to Rican, etc.)	Black, White, etc. Specify: WHITE			
<u>.</u>	n 72 ho "natur	Completed	15. Decedent's Ec (Specify only highest gra	de completed)		Decedent's Usual Occu Give kind of work done life. DO NOT use retin	during most of wo	rking	16b. Kind of Business/Industry			
717	d withii /giene. er than	Som	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAK	ER		OWN HO	OME		
2	ould be filed Mental Hygi arked other atic event, I	To Be	17. Father's Name (First, Middle, Last) ANDREW		REMI	AS	18. Mother's Na MARY		Maiden Surname) GREGORSKI	.)		
, Mary	and 2 should leafth and Men 27 is marke er traumatic	-	19a. Informant's Name/Relationship (19b. Mailing Address (Street and Number or Rural I 7909 RIVERDALE AVE						
200	permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any injury or other tra		20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from State		Disposition (Name of crematory or other plant		Date 17 – 10	20c. Location - City of ELKRIDGI			
Dallillor	permit. Pa Departme Important any injury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		MEALONR	22. Name and Add	TIEUC,			NERAL HOME		
۵	B E E		100			1211 CHE			EDALE, MI			
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each line	the death. Do no	STA LE	DEME	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death		
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of							
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	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of	٥.						
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00	ertifical ding phy e as th											
.O. DOX	e law requires that the death cer has been signed by the attendir je 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
ecords, P	quires that en signed b uld be deta	by	Part II. Other significant conditions of	contributing to death bu	t not resulting in	the underlying cause g	iven in Part I.		obacco use contribute f res 2 ☐ No 3 ☐ F			
Dan	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Euroral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Completed							rmed prior to death?	autopsy findings available completion of cause of		
VII.	ding Physician: The n	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		0 DOA 0	ther:	ath (Check only o				
5	ng Phy: fter this neral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. T	me of jury 28c. Inj			dence 6 Other (Sp now injury occurred	ecity)		
SION	ttendir death. ctor: A the fu	icatic	2 Accident investigation 3 Suicide 6 Could not be	e 29n Place of Inju			□Yes 2□No	28f Location (5	Street and Number or F	Bural Boute Number		
2	talor Ars after al Direction by	Certification:	4 Homicide determined	building, etc	(Specify)			City or Tov	vn, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical			examination and				cause(s) and manner added and place, and du			
	To the Comp	Me	29b. Signature and title of certifier	D		29c. Lice	nse number	7	29d. Date signed (Mor	nth, Day, Year)		
7	70		30. Name and address of person who	haran	8813	Type, Print) Volth	am U	bods	Road.	MD21236		
	Sta Registr		31. Date filed (Month, Day, Year)	Seneral S	r's Signature	2				-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

For State Registrar

Physician

/Medical

Examiner

Decedent's Name (First, Middle, Last)

Lorien Nursing Home

4a. Facility Name (If not institution, give street and number)

Division of Vital Records, P.O. Box 68760,

Funeral Director		5. Social Security Number 192–14–0251	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 86		rs.	If Under 1 Ye Months Da		Jnder 24 ours	4 Hrs. 8. I	Date of Bi (Month, D Irch 10	rth lay, Yea	7)	9. Birt Co Penr	hplace (State or Foreign untry) nsylvania
pu ,		Usual Residence of Decedent													
Maryla f shov	tor	10a. State 10b. County Maryland How	ard	10c. Cr	ty, Town		ott City								10d. Inside City Limits 1 ☐ Yes 2 🛂 No
r 28a	Director	10e. Street and Number					10f. Zip Coo	e				10g. C	Citizen of V	Vhat Co	untry?
th with 23a o	ralD	8255 Academy Road	l				21043						U.S.A.		
er dea items	Funeral I	11. Marital Status	12. Was Dec	cedent Ever in U orces? 2 1 No	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Yes or N in, etc.)	0-		e - Ame k, White	rican Indian, e, etc.	
urs aft	क्	1 ☐ Never Married 2 ☐ Marr 3 🛱 Widowed 4 ☐ Divorced	If Yes, G	ive		1 ☐ Yes 2 ¥ No Specify:						Specify: White			ite
72 ho "natur	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business (Give kind of work done during most of working life. DO NOT use retired)									isiness/	Industry				
within jiene. r than	15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) Telephone								none	Company					
uld be filed Aental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Paul Mistrik	Last)			18. Mother's Name (First, Middle Mary Hudek					e, Maiden Surname)				
and 2 shousalth and No. 27 is ma		19a. Informant's Name/Relations James Urbanski	hip (Type. Print) (Son)								Rural Route Number, City or Town, State, COTT CIty, Maryland 2104				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaning must be notified at once.			4 Donation 5 Other (Specify) Atlantic C						on (Name of Date ory or other place) 2-14-2010			20c. Location - City or Town, State Glen Burnie, Maryland			
permit. Depart Import any inj	21. Signature of Funeral Service Licentee Witzke Funeral Homes, Inc. 5555 Twin Knolls Road columbia, Maryland 210									45					
Physician		23a. Part 1. Enter the dise se, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the deat each line.	h. Do n	ot enter	the mode of	dying, su	uch as c	cardiac or re	spiratory a	arrest,			Approximate Interval Between Onset and Death
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ate be exe hysician a he burial-l		resulting in death) Last	d	or as a conseq	uence of	f):									
requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of a known	al death		Ectopic pregn Other (specif)					23d. Date of delivery Month Day			ivery Day Year
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hysic his ce	To E	examiner? 1 Yes 2	Hospital: 1 □	Inpatient 2	ER/Out	oatient	3 □ DOA	Other: 4	Nurs	sing Home	5 🗆 Res	idence	6 □Oth	er <i>(Spe</i>	cify)
ding P h. After t funera	tion:	27. Manner of Death 1 Natural 5 Pendin	g (Mo.	e of Injury nth, Day, Year)	28b. Ti	me of jury	\	njuryat Vork? □yes	2 □ N		Describe	how inj	ury occurr	ed	
i or Atten after deat Director:	27. Manner of Death 1 Natural 2 Accident 1									er or Ru	ıral Route Number,				
e Hospita 124 hours e Funeral eletely filled	24a. Was an autopsy find prior to completion death? 1 Yes 2 No 24a. Was an autopsy find prior to completion death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route of City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye)														
To th Within To th comp	Me	29b. Signature and title of certified	MD				29c. Lic	ense nur	ther the)					n, Day, Year)
101		30 Name and address of person	who completed cau	use of death (Iter	n 23a) (ype, P	rint)	olun	امار	14 V	Ner	7/4	w 2	10	14
Sta Registra	_	31. Date files (Month, Day, Year)	10 Seren	Registrar's Signa	ature	N.	p								
HMH 17 Rev 1/20	001									-					
					0	RIGI	NAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Ann C. Urbanski

Certificate of Death

4b. City, Town, or Location of Death

Columbia

Reg. No.

2010

4c. County of Death

Howard

1:20 P M

2. Date of Death February

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:41 P M February Joseph Vukov 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 Days Hours (Month, Day, Year) 04/24/1967 Country)
Maryland 42 Director 218-92-4108 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Odenton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21113 1200 Baliol Lane U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Drywall Mechanic Construction Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Elizabeth Fitzpatrick Andrew Joseph Vukov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorene Vukov / Wife 1200 Baliol Lane, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatamy Gifts Registry 02/12/2010 Hanover, Maryland . Signature Funeral Syvice Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ESPIRATORY Physician/ disease or condition resulting in death) Medical Examiner NBUMOWIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner MULI 1545TEM that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical S'EPTIC 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 \square Yes 2 \square No 3 \square Probably 4 $\raisebox{.15ex}{\hsuperbox{χ}}$ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 2 🛣 No 1 Yes 25. Was case referred to medical sompleted filled in by the funeral director, Be 26. Place of Death (Check only one) 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 X Inpatient 2 -ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Accident
Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0043371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (MorFEB 16 2010

200 Registrar's Signature

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY DE 2010 5:55 A VALINSKY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1018 WINDSOR ROAD BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1 🗆 M 2 💆 F Hours Min. 2/15/1969 MD 218-96-6465 40 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 💆 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 1018 WINDSOR ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: should be filed within 72 hours afti and Mental Hygiene. 'is marked other than "natural", 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည of Health and Ments of Health and Ments filem 27 is marked rother traumatic e VALINSKY BETH ROBERT BERNHARDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAGE WOODRUFF/SON 1018 WINDSOR ROAD, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State CARROLL CREMATION 2/12/2010 HAMPSTEAD, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Interval Between nset and Death Immediate Cause (Final +nysician/ 9 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months? Month Veal Day Pregnant at time of death
Unknown 9 Unknown P.O. ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month. Dav. Year) 0 20/0

Registrar

State

Mame and address

JANC 31. Date filed (Month (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February Day WEISER Physician/ SIDNEY 0041 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospita Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🕅 M 2 □ F Months Days Hours Min New York Director 132-03-3935 90 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1400 East West Hwy. 20910 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygician important: If Item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Weiser Frances Haber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene A. Weiser / Wife 1400 East West Hwy. #923, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) 2/10/2010 Beltsville, MD 21. Signature of Funeral Service Librarses

STULL A NHUMMAN 22. Name and Address of Facility
Rapp Funeral and Cremation Services Mc0382 Gist Ave. Silver Spring 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between neumonia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** equentially liet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Dav been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Hypothyroid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I perform 2 🗆 No 1 🔲 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မှ 1 🗌 Yes 2 No 1 🔼 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending s after death. 1 🗌 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours after of Funeral Direct determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number **D61007** 29b. Signaturejand title February

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive #320 Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3836 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Richard Whalen Month 12:42Pm February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Examiner 4c. County of Death Suburban Hospital Montgomery 7. Age (In yrs. last birthday) 78 yrs. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**x**xM 2 □ F **Director** 303-32-2689 3/29/1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director or 28a-f sl MD Montgomery Chevy Chase 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 4800 Chevy Chase Drive #503 20815 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 √ Yes 2 □ No If Yes, Give Korean Year or Dates. Conflict filed within 72 hours after । ध Hygiene. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced Completed ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Medical Construction 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Michael Whalen Alice Louise McCarthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germilina R. Whalen, wife 4800 Chevy Chase Dr. #503 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1
Burial 2
Cremation 3
Removal from State 2/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory of Fune al S 21. Signatur 22. Name and Address of Facilify Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Urinary Tract Infection</u> Days Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diarrhea, Acute Renal Failure, Hypernatremia, Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Advanced Parkinson's Disease, Hypertension 24a. Was an autopsy performed death? 1 Yes 2 No 2XXNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1XXNatural 5 Pending Division 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signativ and title of certifier 29c. License number D53367 February 11, 2010

Registrar
DHMH 17 Rev 7/2009

State

Rajan, Shyamsundar M.D. 9801 Georgia Ave. #117, Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 12,2016 Benjamin ebruary Franklin Wilson /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Marylano LAmore Sprtal TIEN If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) . Age (In yrs. last birthday 6 Sex **Funeral** Days Hours 1⊠ M 2□ F 228-38-5186 Director 76 04/19/1933 Virginia Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 XiYes 2 □ No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1513 Clifton Ave Funeral 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🎦 No Specify Completed by Specify: 3 Widowed 4 Divorced Black "natural", er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cossentag Contract Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Construction Co Labor is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be t Health and Mental Arthur Wilson ပ Christine Worsham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Samuel Wilson(Brother) 10541 Thompkin LN, Amelia, VA 23003 20b. Place of Disposition (Name of Cemelery, crematory of other place)
Manassa Hill BAPT
Church Cemetery 02/12/10 Pages 1 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Amelia, Virginia_ 21. Signaure Funeral Service Licensee ²² Name and Address of Facility Hawkes Funeral Home acre 15001 Patrick Henry Hwry., Amelia, VA23002 234. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** phoma M /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ove to for as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy detached for Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown ۳. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 **1**No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Funeral rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier (Check only one) and manner stated. the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Day, Physician/ D. Worsley 2010 3:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 364 Cork Rd. Glen Burnie Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🖾 M 2 🗆 F Hours Min. 240-72-2654 63 4-127-13 46" Director Yrs. NC Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 😾 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 364 Cork Rd. 21060 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or i Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🔀 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 🗌 Widowed 4 🗌 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NSA Government Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nellie G. Mustian James Doak Worsley Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $364\ Cork\ Rd.$, $Glen\ Burnie\ MD\ 21060$ Ruth Worsley / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State Oak City Cemetery 2/12/2010 Oak City, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Hor 421 Crain Hwy., S.E., Glen Signature of Fundral Service Lice M01364 MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ta. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ned by the a detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 🔀 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 🔀 No ျ 4 🗌 Nursing Home 5 🛛 Residence 6 🗆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide neral Director; A I filled in by the f Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 010 D31551 30. Name applications of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State

31. Date filed (Month, Day, Year)

Russell DeLuca, M.D., 305 Hospital Drive, Glen Burnie, Maryland 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Year Physician 16:30 M ABON M WINSTON FEBRUARY 010£ PO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOHUS HOPKIUS BAYVILE W MEDILAL CENTER BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1**⊠** M 2□ F 251-60-457 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the rediffed at 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? 10f Zip Code Street and Number U.S. 21206 Funeral Dravio . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 00 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19Yave 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number o Rural Route Number, City or Town, State, Zip Code) 410 Md. 21206 lattic Winston Moravia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 1701 McCullon Balto. Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Joch line. Immediate Cause (Final disease or condition resulting in death) VIENTRICULAR FIBRILLATION **Physician** 3 minutes /Medical Due to (or as a consequence of): Examiner >10 years HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Box 68760. P.0. Division of Vital Records, the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29b. Signature and title of certifier

RES-000

FEBRUARY OF 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN AVENUE, BALTIMORE KRISTINA FROGA LE M.D.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician/ Weishorn Richard 3:10 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Baltimore 112 Winifred Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Ye Hours Min. Year) Pennsylvania 1 X M 2 □ F Director Sep. 1930 181-22-5057 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director New Paris 1 🗆 Yes 2 🏝 No Bedford PA10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15554 USA 240 Cardinal Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: white and Mental Hygiene. 3 Midowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should te filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Businessman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary McVickers ပ Herman Weishorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1713 Wilmington Ave. Baltimore MD 21230 Kevin Weishorn-son Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) West Arundel Crematory 2-9-2010 Odenton MD 2. Name and Address of Facility Ambrose Funeral Home Of Lansdowne 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition Medical resulting in death) Examiner onaNani years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be daughters 2 No Hospital Other 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WHEELTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2304 Smith Avenue Lansdowne Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Sex 1 AM 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Yrs 74 **Director** 213-32-1390 15, 1935 Maryland Dec. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exymitme I must be insufficed at MD Baltimore Lansdowne 1 □Yes X□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2304 Smith Avenue 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White <u>\$</u> 3 Widowed 4 Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonard Tarr Wheelton Mary Holt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Wheelton, Sr. - Son 2304 Smith Avenue, Lansdowne, MD 21227 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Bunial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 2-13-2010 4 Donation 5 Other (Specify) Baltimore, MD 22 Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 419 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending PhysIclan: The law requires that the death certificate be executed 24 hours after death. burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Ves 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Mopth, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 1 Divatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical anner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURMO 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar Year)

				1 - State of Maryland / Dep	partment of Health and leartificate of Death	Mental Hy	rgiene	03842
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		Physici /Media		Robert Blackistone White		Februa		0 9:30 PM
4		Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Dea	h I
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		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 8.6 Yrs.	Months Days Hours Min.	8. Date of Bi	th Year 923 Per	hplace (State or Foreign
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		and and		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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T		3a o	<u>=</u>	206 Drake Court	21078		United Stat	es
7		death	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or N	0- 14. Race - Ame	
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4	2	s 1 and 2 should f Health and Mer tem 27 is marke other treumatic		Katherine Le Guin White/Wife 206	Drake Court Havre	de Grad	ce, Maryland	l 21078
0	altimore,	es 1 and 2 of Health of Item 27 i	i i	20a. Method of Disposition 20b. Place of Disposition comptent, cre	position (Name of ematory or other place) neral Chapel Feb.	Date O5	20c. Location - City or	Town, State
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	alti	permit. Pages Department of Important: If i any Injury or once.		21. Signatur Funeral Service Licensee	22. Name and Address of Facility	2] & Cre	emation Serv	rice_Belair
	<u> </u>	89 5 9		Joux Chay	^{22. Name and Address of Facility} Vans Funeral Chape 3 Newport Drive Fo	orest Hi	ill, Marylar	d 21050
				23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	or respiratory a	arrest,	Approximate Interval Between Onset and Death
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		/Medical Examiner		resulting in death) Due to (or as a consequence of):	J			(
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	Θ.	hat th ad by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?
	ds,	Physicien: The law requires that the death certifics this certificate has been signed by the ettending pt ral director, pege 2 should be detached for use as t	d by		. ,	172	Yes 2 □No 3 □ Pi	obably 4 []Unknown
	Š	w requir been si should	lete			24a. Was	an 24b. Were a	utopsy findings available
	Be	The law cate has pege 2 s	Completed				ormed2 prior to death?	completion of cause of
	ta	ılclen: Th certificate rector, peç	BeC	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes		20110
	Ž	Physicle this cert ral direct	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing H	lome 5 Res	idence 6 Other (Spe	cify)
	0 4	ng Ph ter th neral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe	how injury occurred	
	Sio	sndir eath. or: A	catic	2 Accident investigation	M 1 Yes 2 No			
	Division of Vital Records, P.O. Box 60	or Att	Certification;	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location City or To	(Street and Number or Ri wn, State)	ural Houte Number,
		To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the	cause(s) and manner as	stated.
با	1	e Hos 24 h Fur letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	irred at the time	, date and place, and due	to the cause(s)
107	_	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
				1 (July & ann mo	Bo05418		2-5-6	ð
				30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	1	11 -	
				31. Date filed (Month, Day, Year) 32. Refistrar's Signature	so Bay vin Coll	- 13a	I Prome ma	21224
		Sta Registr		FEB 16 2010	hadel			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 **Physician** February 2010 3:29 P M Michael H. Weir Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson
If Under 1 Year Greater Baltimore Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
March24,1924 If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Days 1₩ M 2□ F Months Hours Min 219-14-2074 85 Director MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tien 27 is ansked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "sactical Eventure in ait to notified at 10d Inside City Limits Director 1 ☐ Yes 2 TNo MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611Weir Lane 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

X Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: White timore, Maryland 21215-0030 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self-employed 2yr MAson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Weir Marie E. Schissler ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Weir Jr. 613 Weir Lane Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 2/13/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f in neral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a devere asperation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Can Dladder burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) the 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page 2 s autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

marie 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Carolyn M. Wagner 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ital re H 0 7. Age (In vrs. last birthday) 8 Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Months Days Hours Min. Dec. 8, 1932 216-28-5446 77 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Baltimore Middle River 1 ☐ Yes 2X No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9754 Matzon Road 21220 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. n C しんたの し Maryland 21215-0036 þ 1 Never Married 2 Married Yes 2x No If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White Specify: Completed 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Gilbert John Panuska Elizabeth Lanterbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gailynn Vinias /Daughter 1 Oldfield Court Baltimore MD 21220 3altimore, Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Commetery, crematory or other place)
Parkwood Cemetery 2/15/10 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Farar a Lice 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fa disease or condition Medical resulting in death) Examiner Da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a conseq e of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23h Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 X No Month Day been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 X No death? 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 X No 은 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a

To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 428 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2123 Md MD 9000 PKIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** DUSOAM Wilson tesruary Marian Α. 200 /Medical 4b. City, Town, or Location of Death
Balfon Ove 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ACNU55 ATMITA HOSPITON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2√□ F 20 89 Director 217-20-4283 ĎΕ Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sh Director 1 X Yes 2 □ No MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 2824 Presburg Street U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Ferra Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4or 5+) Clerk Social Security Adm. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Burton Vernon Hearn ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 River Run, Queenstown, Md 21658 Leslie Hearn-Son 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/18/2010 Woodlawn, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee March Fyh West 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part |. Enter the disease, or complications that cause if the death, shock, or heart la ure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran attending physician and for use as the burial-tran be exec resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No 5 ☐ Other (specify) P.O. After this certificate has been signed by the a funeral director, page 2 should be detached a 9 Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifie 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month

Day, Year)

10-00978 Mark Warren Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day February 2, 2010 Medical Examiner 2204 hrs Warren nark 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 7230 Gough Street **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Hours Director 1 M 2 F -84-569 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County IMORE, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No mIDirector 10g. Citizen of What Country? 10e, Street and Numbe 10f Zip Code 2122 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S ed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Yes Jack 3 Widowed Divorced Yes, Give Year 1 Yes 2 No specify: Specify: þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Police C 18 Mother's Name (First, Middle, Maiden Surname Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address et and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name timore, 2 Cremation Removal from State 3 Department of Important: I Donation 5 Other Specify. 21. Signature of Funeral Service Licen-23a. Part I. En et the disease, or amplication failure. Les only one cause on each line Approximate Interval the disease, or Amplications that caused the death. Do not enter the mode of dying, such as Physician /Medical Death a Multiple Cutting Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and for use as the burial - transi Physician/Medical UNPENDED AMENDED law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth use as t Fetal death past 12 months? Pregnant at time of death 5 signed by the atte 1 Yes 2 No 9 Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After the the funeral director, 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 ER/Outpatient 3 DOA Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject cut self FOUND: 1 Natural Division 1 Yes 2 V No Pending To the Funeral Director: completely filled in by the Feb 2, 2010 2200 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 7230 Gough Street, Baltimore, MD determined (Specify) Family Home Homicide 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 3, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) FEB 1 6 201 32. Registrar's Signature State OCME Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Son 08:15 AM 8 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Kesville Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 Hours Min (Month, Director Indies ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No more 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 21208 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or þ 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced If Yes, Give Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) and Mental Hygiene. mestic is marked other Be permit. Page 1 and 2 should be filed of Department of Health and Mental Hyg Important: If item 27 is marked otheny injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 19a, Informant's Name/Relationship (Type, Print) Rural Route Numbe , City or Town, State, Zip Code) 19b. Mailing Address (Street and Numbe 50n Kesville MD 21208 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) O Sy Kesville MD Gredne Funeral Services 20-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 8728 Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BiliARY Ph_sician/ ADENOCALCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) Day Pregnant at time of death within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached to g Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Hospital or Attending Physician: Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?

1
Yes Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier ٥ 2088852 CKNY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Source Siamon 1 2835 Smint Ausnus. SALTIMOLE 2835 31. Date filed (Me State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Deceden 's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year lilliams **Physician** exander 1104 PM 06 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Yrs. Birthplace (State or Foreign Country) Social Security Number Funerai 220-22-1444 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its insolical Evantment must be notified at tonsville 1 □ Yes 2 **5**0 Director 10g. Citizen of What Country? 10e. Street and Number USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 152Yes 2 [KYes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 ☐Yes 2 No Specify ģ Blac 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work dane during most of working
life. DO NOT useratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) ler Name (First, Middle, Last) Be illiams, Baltimore, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐Other (Specify) Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Days MRSA Bacteremia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4: Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 1 Tyes 2 1 No of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the Funeral Director: After this filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury . (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 924056 M.D FEB 06, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave, Baltimore MD 21229 Amjad St. Agnes Hospital taria

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mary Isabel Wilcox February fo, 2010^{ea} 8:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Oct. 4, 1921 88 Minnesota **Director** 474-16-3829 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Montgomery Village Montgomery 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be with 1 Funeral 20886 United States 18101 Kilrush Court hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi of Health and Mental item 27 is marked ပ Telford Henry Chilstrom Isabel Margaret Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Mary Wilcox Brooks/Daughter 422 Bostwick Lane, Gaithersburg, Maryland other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) February 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 18**,**2010 Silver Spring, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. Mellian M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Onset and Death Physician/ Bleeding Duodenal Ulcer days Medical resulting in death) Due to (or as a consequence of) Examiner Severe Anemia 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Aspiration Pneumonia 2 days Cause (Disease or linjury that initiated events resulting in death) Last an Due to (or as a consequence of): nding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 Yes 2 No ğ 5 Other (specify) Month Day Year Pregnant at time of death the detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signe be c 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 \(\text{No.} \) 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 X No မ 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

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Belay Atnafu,

FEB 1 6 201

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

29c. License number

0069750

9901 Medical Center Drive, Rockville, Maryland

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan	7	irtment of H tificate of l		nd Mental Hy	/giene Reg. No:)	010	02850
27	Dharaisi	Ш	Decedent's Name (First, Middle, Last)					2. Date of D Month		Year	3. Time of Death
~	Physici: /Medic	al	THELMA RITA	WALSKY		4b. Citv. Town, or	t anotion of	FEBR	JARY 9		04:40P™
}	Examin	er	4a. Facility Name (If not institution, give s KESWICK MULTICARE	reer and number)		BALTIMO		Death	40.00	ounty or Death	N/A
- 24	Funeral	0,	5. Social Security Number 6. Sex	7. Age (In yrs. i		If Under 1 Year Months Days		Min. (Month, D	rth ay, Year)	Coun	ace (State or Foreign try)
	Director		215-05-2571 Usual Residence of Decedent	244	90 Yrs.			06/19	9/1919		MD
	ryland how at		10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	he Ma 8a-f s	Director	MD N/A	BA	ALTIMO				10- Citi	6 \M/h - 1 O - 11 -	1 X Yes 2 No
	leath with the Marylan ns 23a or 28a-f show must be notifled at		10e. Street and Number 700 W. 40TH STREE	т		10f. Zip Code 21211			rog. Gilize	n of What Coun	USA
	death	Funeral		Was Decedent Ever in U. Armed Forces?	S. 13. \		ispanic Orig	jin? (Specify Yes or N , Puerto Rican, etc.)	0- 14	. Race - America Black, White,	an Indian,
36	d within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 23a-f show the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🗖 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		l ☐ Yes 2 🛣 No	Specify:	,		pecify: WHIT	
0	2 hour	ted b	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occup	ation	-6adda-a	16b. Kind	WILI of Business/Ind	
215	within 7, iene. than "n he Medi	Completed	Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life. L	kind of work done o	1)	or working	DETAI	u DET o	UDDI TEC
121	e filed w al Hygier other th		12 17. Father's Name (First, Middle, Last)			<u>OWNER</u>		r's Name (First, Middl			SUPPLIES
lan	ould be a Mental arked o	To Be	SAMUEL		RANKI	۱	ANNA	•		BREE	EN
Maryland 21215-0036	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked othe or other traumatic event,		19a. Informant's Name/Relationship (Typ			•		r or Rural Route Num	-		-
	1 and Health em 27 ther tr		STEVEN WALSKY / S 20a. Method of Disposition					REDERICKSE Date		VA 22406	
mor	Pages nent of int; If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other plac DUNG MENS		/14/2010		ODLAWN,	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License		22	. Name and Addres	ss of Facility	SOL LEVIN	SON &	BROS.,	INC.
Ω.	9 2 E E 6		- HoffM	Wille	89	900 REIST	ERST0	WN ROAD, P	IKESV	ILLE, MI	21208
	14.1	W 1	23a. Part . Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
×	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ		EVEN	LID				
	Examiner		Sequentially list conditions, b								
))	uted Insit	mine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	uence or):					: 1	
o o	execu an and irial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d								
Box 6	certifii nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant 2.	3c. If yes, outcome pf pregna					23	d. Date of delive	ery
	o o o	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)	y 			Month	Day Year
P.0	law requires that the de as been signed by the a 2 should be detached		9 ☐ Unknown Part II. Other significant conditions con		ultina in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	e contribute to the	ne cause of death?
or Vital Records,	quires t n signe	d by				, , , ,		1 [Yes 2	No 3 ☐ Prob	ably 4 Unknown
OOE	law requir as been si 2 should b	Completed						24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of cause of
Æ	The ate has page	Com						per 1□ Yes	formed?	death?	2□No
Vita	Physician: The this certificate ral director, par	Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatier	at 3 DOA Oth	or.	of Death (Check only		To:: 10 ''	
		n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o			rsing Home 5 Re 28d. Describe			<u>y) </u>
sior	Attending I r death. ector: After by the funer	catio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ N				
Division	I or Attend after death Director: ,	Certification:	4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif		eet, factory, office			(Street and own, State)	Number or Rura	il Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	cal C		sician: To the best of my kno ner: On the basis of examina							
	the H thin 24 the F mplete	Medical	one) 29b. Signature and title of codifier	and manner stated.		29c. Licens				signed (Month,	
	T × C		Designation of the off control	M	0		5590	56	2	11/10	,,,
	10		30. Name and address of person who co				~ (~			J	
	W		31. Date filed (Month Day, Year)	MO To	D WES	+ 40th S	it R.	e1+ MD	2(2)		
	Sta Registi		FEB 1 6 2010	Centra d	ba						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a per dr., g 00,02/16/10dib ealth and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WELLS Nashira Jan 31, 2010 2350 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** N/A JHH-Bayview Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Manths | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs Director 219-83-9545 Feb 22, 2009 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Xes 2 □ No Director **Baltimore** Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4407 Willshire Avenue 21206 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2☐No Yes, Give X 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify ģ 3 Widowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Never Worked** Infant -0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Wells Jr. Nakia Quick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Wells 4407 Willshire Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Bun'al 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/04/10 Baltimore, Md. Western Cemetery 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hydrancephaly /Medical Due to (or as a consequence of): Diabetes Insipidus **Examiner** Hydrancep Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No certificate 1□ Yes Division or Vital To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Tes 20 No 1 | Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0051344

State Registrar 31. Date file

wolfe st Baltimore, MD 21287

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's S

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 11:32 AM J C Walter 8 Jan 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 51. Ag hea 5. Social Security Number Baltinone Under 1 Year | If Under 24 Hrs. Hospital N/A 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 → M 2 □ F Months Days Hours Min. 253-40-9185 84 Mar 22, 1925 Georgia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3530 Resource Drive 21133 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Longshoreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown **Emily Forest** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Walter 3530 Resource Drive Randallstown, Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/03/10 Windsor Mill, Md. King Memorial Park 21. Signatur pof Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Pheunonia disease or condition resulting in death) Davi Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an performed 1∏Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Specify) 27. Manner of Death

Physician /Medical **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed

Physician

Examiner

10a. State

Director

Funeral

þ

Completed

Be

မ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Modical Exaction must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other traumatic evant in the page.

/Medical

the burial-tran physician attending pl cate has been signed by page 2 should be detach certificate has funeral director, After this

Completed by

Be

Medical Certification: To

P.0.

Records,

Vital

Division of

Walter

or Attending Physician:

Hospital

within 24 hours after death To the Funeral Director:

filled in by

1 Natural 2 Accident

	Hospita	al: 1 npatient	2 🗆	ER/Outpatient	3 🗆 1	OOA	Other:	4 ☐ Nursing H	ome	5 Residence	6 ☐Other (
☐ Pending investigation		a. Date of Injury (Month, Day, Yo	ear)	28b. Time of Injury	М	28c.	Injury at Work?	2 □ No		Describe how inju	

3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

M·D

P23748

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dagaha

900 Caton Hyenue 32. Registrar's Signature

Baltimore, Maryland

21229

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year Kurvar **Physician** 28 2010 12504 John L. Wright /Medical 4a. Facility Name (If not institution, give street and number, Town, or Location of Death 4c. County of Death Examiner BALTEMOR HOSPITAL [Acros AGNES N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2□F Director 212-34-8520 Mar 26, 1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Middel Evander and Demoilled an 1 ⊈Yes 2 ☐ No Director Maryland **Baltimore City** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 Old Orchard Road Funeral 21229 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. 2 Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Minister permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) a ပ George Lee Wright Joanna L. Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Old Orchard Road Baltimore, Maryland 21229 lda Wright Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/05/10 Columbia, Md. First Baptist Church of Guilford 21. Signature of Funeral Service Licenses 2. Name and Address of Facility Estep Brothers Funeral Service, P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** Planoma Vntonou /Medical Due to (or as a consequence of): **Examiner** Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur as a consequence off certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for (Month in the past 12 months? Day Year Pregnant at time of death 4 Pregnant 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No the detached 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Vital 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ Division of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) JOHN 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) resienor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARMIT AGNES GERREWOLD

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registr <i>a</i> r	State of Ma	-	Sertificate of		•	Reg. No. 201	0 03854
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Ye	3. Time of Death
- Tille	/Medic		Robert A. Woehl			T 01. 7			/2010 Ye	2:10 A M
	Examin	er	4a. Facility Name (If not institution, give s Keswick Multi (or Location of Deat imore	:n	4c. County of E	
and you	Funeral		5. Social Security Number 6. Sex		(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign
b	Director		219-18-3963 1X	M 2□F {	3 4	s. Months Days	Hours Min.	3/8/1		Maryland
	yland Jow		10a. State 10b. County		10c. City, Town of					10d. Inside City Limits
	a-f si	ctor	MD Baltimo	ore	Halet	norpe				1 □Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
	s 23a	eral	3308 Benson Ave			212		>if . V N-	USA	American Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities in that it and once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 Was Decedent E Armed Forces? 1 X Yes 2 □ Notes If Yes, Give Year or Dates: 		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No		to Rican, etc.)	Black, V	American Indian, Vhite, etc. White
5-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Decedent's Usual Occu Give kind of work done	during most of wo	rking	16b. Kind of Busin	ess/Industry
121	vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. DO NOT use retire ales	d)	0	Retail	
	Hygie Hygie ther t	ပ္ပ	1 2	0	30	ares	18. Mother's Na	me (First, Middle,	Maiden Surname)	
Maryland	d be i ental ked o	To Be	William Woehlke	7			Eloise	,	ŕ	
ary	shoul and M mar umati	F	19a. Informant's Name/Relationship (Typ		19b. l	Mailing Address (Stree			er, City or Town, Sta	ate, Zip Code)
Σ̈́	and 2 salth a 27 ls		Barbara W. Beck	kett / D	au. 846	2 Kenton R	oad, Pasa	adena, M	aryland 2	1122
ore	es 1 g of He fitem roth		20a. Method of Disposition	ameual from State	20b. Place of E cemetery,	isposition (Name of crematory or other pla	ice)	Date	20c. Location - City	y or Town, State
Ĕ	Pag ment ant; I		1 ☐ Burial 2 【A Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	Bayview	v Crematory	2/1	5/2010	Baltimor	e, Maryland
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service License			22. Name and Addr			Funeral Ho imore, Mar	ome, Inc. cyland 21229
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			- Acciden	+			Onset and Death
J	/Medical		resulting in death)		consequence of					
	Examiner	ڀ	Sequentially list conditions, b		r					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. End industry Cause (Disease or injury that initiated events	Due to (or as a	consequence of):				
	tificate be executed g physician and as the burial-transit	xar	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):				
68760,	e be sicial	cal	L _d							
9	tificat ig phy as the	ledical		1841			10/05/42			
O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date o Month	
P.0.	that the	Ph)	Part II. Other significant conditions con	tributing to death bu	t not resulting in t	he underlying cause gi	ven in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
ords,	equires ten sign ould be	ted by						10	Yes 2□No 3[Probably 4 Unknown
Division of Vital Records,	The law r ate has be page 2 sh	Completed						24a. Was auto perfo 1 □Yes	psy prio prmed? dea	re autopsy findings available in to completion of cause of th? Yes 2 □ No
/ita	Physician: The rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?			100		ath (Check only o		
of \	Physi this c		To tes 2010	·		batient 3 LI DOA		1	dence 6 Other	(Specify)
u	ding I J. After funer	ion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Tir (<i>Year)</i> Inj	ury Wo	nyat rk?]Yes 2 ∐No	28d. Describe	how injury occurred	
isi	Attending It death. ector: Afte by the fune	Certification: To	3 ☐ Suicide 6 ☐ Could not be			n, street, factory, office	1163 2 1110			or Rural Route Number,
<u>S</u>	al or / s after I Dire	erti	4 ☐ Homicide determined	building, etc.	."(Specify)			City or To	wn, State)	
rl	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C			examination and	death occurred at the /or investigation, in my				
1 1	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (A	Month, Day, Year)
	- > - 0				NO	7	005405	6	2/13/1	0
			30. Name and address of person who co	mpleted cause of de		ype, Print)	+ 40m	2 2		
			Daljeet Salve	a MD	1-01	100 Mes.	+ 4020	24 R.	FA- MO	21211
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6 2010	52. Hegistra	r's Signature	ses!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 16:35 PM FEBRUAR! 10 MARY XINTAS 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/AJOHNS HUPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F Director 232-20-3296 87 FEB. 24, 1922 ILLINOIS Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Examinar mast be notified at Director 1X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 806 RAPOLLA STREET Funeral 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH 0 OWNER TRIANGLE TAVERN permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important: If item 27 is marked other i any injury or other traumatic event, !!! 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DANIEL BISBIKIS IRENE YIANOUDIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN A. XINTAS/SON 923 FOXWOOD LANE, ESSEX, MARYLAND 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREEK ORTHODOX CEM. 2/18/2010 | BALTIMORE, MARYLAND 21. Signature of Euneral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List per, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PERITONITIS 10 DAYS /Medical Due to (or as a consequence of): Examiner 10 DAYS RUPTURED VISCOUS Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Hospital or Attending Physician: The 1 □Yes 2 No 2 🗆 No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 MNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEBRUARY 10, 2010 anno RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

State Registrar

negistrai

ELIZABETH

32. Registrar's Signature

HARRIS, MD 4940 EASTERN AVENUE, BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lewis H. Young Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 0 rare If Unde Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Social Security Number **Funeral** 9. Birthplace (State or Foreign Months Days 1 ★ M 2 □ F Hours 217-12-7644 Yrs. Country Director 86 Marvland Usual Residence of Deceden or 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2908 Ontario Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces:

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married 2 🗌 No WII 1 ☐ Yes 2 🛣 No Specify: 'natural", Completed 3 😾 Widowed 4 🗆 Divorced Specify White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Brick Laver 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve anns. 2 John W. Young Marrie Denson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Young/ Son 1934 Mountain Avenue, Baltimore, MD 21234 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Pel Air Memorial Gardens 02 /09/2010 Bel Air, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, Maryland 2123/ 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 2000 se or condition d Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequen) of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death
Unknown 1 Yes 2 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Suicide Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February W. Young Nancy 11 2010 11:40 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Mays Chapel Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Months Days 301-32-4020 71 Director Feb. 26. 1938 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Medical Evertines must be realised anone. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 □Yes 2√ No Md. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2136 Nodleigh Terr. 21084 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Ś Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Assistant Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Α. Warfield Robert Martha ဥ Bracken 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. R. Bruce Young/ Husband 2136 Nodleigh Terr. Jarrettsville, Md. 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Presbyterian 2-19-10 White Hall, Md. 21. Signature of Funeral Service Ligensee 22. Name a RACKS TOWSON Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) avdias **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any later in the conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1∐Yes 2∐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

30 1

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signa

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAN-CARDEN

32. Registrar's Signature

Leneur S. Sparks

N Charles

D61731

4105, BALTO, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last)
Annette Zurlo 3. Time of Death 2. Date of Death 8:50pm 01/26/2010 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Lands of Severna Park Severna Park Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3 / 5 / 1 9 1 2 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 577-60-1951 **Funeral** 1 M XX 97 Director Wash DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "-- and injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Severna Park MD Anne Arundel 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 715 Benfield Blvd 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X X o If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify. ð white 3 ₩idowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Russo Concetta Varanelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen A. Zurlo / Grandson 759 Stacy Oakway, Millersville MD 21106 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Calvary Cemetery 1/30/2010 Waterbury, CT 4 □ Donation 5 □ Other (Specify) Doda^{2. Name} and Address of Facility
Charles L. Stevens Funeral Home, In
1501 E. Fort Ave, Baltimore MD 21230 21. Signaple of Funeral Service Licensee Victor P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years adv 9000 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Tyes 2 No 3 Probably 4 Denknown page 2 should Completed peen Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perforn Physiclan: 25. Was case referred to edical examiner? funeral director, 26. Place of Death (Check only one) Be 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner 28b. Time of 28d. Describe how injury occurred eath 28c. Injury at 1 tural al or Attending F after death. | Director: After After 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C Hospital 1 Crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number Signate 29d. Date signed (Month, Day, Year) 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ans HWM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lorraine Grace Zerbe Month Year Physician/ 8:10a[™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Somerford Assisted Living Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 06/20/1927 Months Days 1 M 2 F 206-20-1808 82 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4720 Yorkshire Drive 21043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 white 1 Yes 2 No Specify: 3 ₩Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Housewife Own Home 12 0 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Donton Anne Bohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Lucy Zerbe / Daughter 4720 Yorkshire Drive, Ellicott City MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Peter's Cemetery 2/13/2010 Orwin, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr 22. Name and Address of Facility
Charles L. Stevens Funeral Home,
1501 E. Fort Avenue, Baltimore MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Parkinson's Disease 15 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 24 No Day signed by the a d be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? Yes 2 ☑ No 2 🔀 No 1 Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Assisted 2**XX**No 1 🗌 Yes 4 Nursing Home 5 Residence Other (Specify, မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Living 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred al or Attending Is after death. Natural 5 Pending Division 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X-certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2/11/2010 29b. Signature and title of certifier D 56531

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month)

68760

Box

Harry Li, MD 8600 Snowden River Pkwy #301, Columbia MD 21045

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per th g900 2-16-10 vt State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $^{\text{Day}}_{12}, 2010$ Febrary Daniel 9:25 A M Mver Zoppo Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Cntr. Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 01^{Month}3^{Pay,}19945 218.40.3333 Director 65 Usual Residence of Decedent or 28a-f show 10b. County 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 935 Rodman Way U.S.A. hours after death 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4. Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed unk Misc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Peter Gus Zoppo Mary Jeanette Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Nena Blackwell/daughter 1110 Pelham Wood Rd., Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) eake Crem. 102.13.10 Beltsville, MD
22. Name and Address of FaciliCAFA/Stephen D. Lohrmann, PA Chesapeake Crem. 21. Signature of Funeral Service Licensee H01443 8717 Green Pastures Dr. Balto., MD 21286 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury Directo (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available 24a. Was an has page 2: prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27, Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

har

gistrar's Signature

6-701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lois E. Zinck Fobruar 2010 Medical 4a. Facility Name (if not institution, give street and numbe Examiner County of Death Himore Washington Med burnic 8. Date of Birth (Month, Day, Feb. 27 **Funeral** If Under 24 Hrs. 1 M 2 X F Months 216-24-5256 Maryland 80 Director 1929 Usual Residence of Decedent 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7466 Furnace Branch Rd., Apt. 420 United States 21060 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 3 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence M. Ritter Edna E. Storm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce E. Zinck / Son 112 Earliana Ct., Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Feb. 2010 Crownsville MD_Vet. Cem. Crownsville, Maryland 21. Sig ature of Fun ral per Name and Address of Facility related Home, P.A. rkley-Ruddick Funeral Home, P.A. Crain Hwy., S.E., Glen Burnie, 91 MD 21061 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 6VOVASE disease or condition NO Medical resulting in death) Due to (or as a consequence of) ²Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a, Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death? perform After this certificate 2 No ☐ Yes 1 Yes the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 No ည 1 Tyes 1 Inpatient 2 🗆 Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier ٥ 30. Name and address of person who completed cause of death (Item 23a) (Tipe, Print) Wospital

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month V . Allmond Ouincie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Sinai Hospital</u> Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Months Days Hours Min. (Month, Day, 3 07 Director 215-28-2850 77 NC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 10d. Inside City Limits MD NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 2550 West Coldpspring Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. Completed by ō 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural", 3 ▼ Widowed 4 □ Divorced nt of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Homemaker House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Conrad Harris Virginia Williams t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 2550 West Coldspring Lane, Baltimore, Lawrence Allmond-Son |\tag{\CC1}\ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Memorial 2/22/10 Arbutus, Md Arbutus Park 22. Name and Address of Facili March F. H. We 4300 Wabash ture of Funeral Service Licensee št Ave, Baltimore, 23a. Pan 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immeriate Cause (Final Onset and eath Physician/ ease or condition resulting in death) Medical Due to or as a consequence of Examiner Seque traily liet on citions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed bours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Pregnant at time of death Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation after death 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Ho...
an 24 hours
o the Funeral Di
completed filler Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 7/2009

egistrar's Signatur

Physician /Medical **Examiner**

sician and burial-transit

The law requires that the death certificate be executed

Box 68760.

P.0.

of Vital Records,

Division

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shore Examiner must be notified at

or i

al Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 Is marked oth

Department of Health Important: If item 27 any Injury or other tr

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

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Physician/Medical Examiner

3

Completed

Be

Certification: To

Medical

Director: /

within 24 hours a

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

5 Pending

investigation

6 ☐ Could not be

1 Yes 2 No

examiner?

27. Manney of Death

1 Natural

2 Accident

3 ☐ Suicide

(Check only one)

IF FEMALE:

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Date of Injury (Month, Day, Year)

24a. Was an autopsy performed

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

29b. Signature and title of certifier

21776

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURUA 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

2 🗌 No

24b. Were autopsy findings available prior to completion of cause of death?

2 1 Kg

1 ☐ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

FERRUARY 15, 2010

MUNDRA MY 2001 SOUTH HAWVER ST, BARTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03864 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 501 PM MARY LOUISE ADAMS 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 30, 1 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 X F Maryland Director Yrs 217-16-1437 88 Usual Residence of Decedent 28a-f shov 10b. County 10a. State event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Forest Hill 1 Yes 2 No 10e, Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 1995 Cullen Way 21050 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Evel Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. "natural", Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Oliver Emmons Mary Elizabeth Humerickhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1995 Cullen Way, Forest Hill, Maryland 21050 Donna Adams / Daughter Page 1 and Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest VA Cem 3-2-10 Owings Mills, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an as Se perform certificate 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ♣ No Other: မ 1 Propatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 - Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number upper Chesapaa who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

ebruary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 03865 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nanna Gertrude Brown February 15, 2010 10:05 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Essex
If Under 1 Year | If Under 24 Hrs.
Hours | Min. 10 Ridgemoor Road 5. Social Security Number 6. Se Baltimore 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F 217-32-7703 1/17/1936 74 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6524 Clear Drop Court 21060 A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 □Yes 2√2 No Specify. 3 Widowed 4X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 12 Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Gladvs Abbott Jerome 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6524 Clear Drop Court Glen Burnie, Maryland 21060 Charles Albert Brown (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/10 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS Due to (or as a consequence of): Sequentially list conditions, Due to for as a page-duagrop of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4 Pregnant at time of death 5 Cher (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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r than "natural", or items 23a or 28a-f shouthe Medical Exprimer must be notified at

death with the Maryland

within 72 hours after

and Mental Hygiene.

Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic evonce.

Pages 1 and 2 should be 1 nent of Health and Mental

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

/Medical

burial-trar

Examine attending physician for use as the buria detached page 2 should has

After this ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t completely filled in by the Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Physician/Medical þ Completed Be Certification: To

within 2 To the I

5 State

Registrar

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

MO

28a. Date of Injury (Month, Day, Year)

29c. License number

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗆 Yes

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Mother (Specify)

26. Place of Death (Check only one)

autopsy performed

28d. Describe how injury occurred

1 ☐ Yes 2X No

BALTIMORE MD

. Were autopsy findings available prior to completion of cause of death?

2 No

Sister's Residence

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IM, MD

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland		rtment of F tificate of			giene leg. No. 2010	03866			
Physici /Medic		1. Decedent's Name (First, Middle, L	Brown				2. Date of Deal	S ZOI	v / pm			
Examir Funeral Director	ner	4a. Facility Name (If not institution, g Seasons Hospice 5. Social Security Number 6. 218–26–5991	Sex 7. Age (In yrs. Ia.	st birthday) Yrs.		LStown If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of Deal Baltimo				
Maryland a-f show	ctor	Usual Residence of Decedent		Town or Loc					10d. Inside City Limits 1 □ Yes 2 □ No			
ath with the 23a or 28	ral Director	10e. Street and Number 4109 Fox Hollow Lane			10f. Zip Code 211			0g. Citizen of What C				
Dealtilliore, Marylating ZIZ (3-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show withingty or other traumatic event, the Medical Exemples rount by nortified at once.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ Yho If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐Yes 2 1 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whit Specify:	erican Indian, te, etc. ican-American			
Z I Z I 3-00.30 d within 72 hours aft glene. er than "natural", or the Medical Exenti	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occup kind of work done DO NOT use retired L Assistan	during most of work d)		16b. Kind of Business Dr. Paca Dent	-			
arylarid should be file and Mental Hy marked othe umatic event,	To Be (17. Father's Name (First, Middle, Las Gilbert Flood	st)			18. Mother's Nam Mattie Jo		Maiden Surname)				
Dallimore, Mary viaing praining servinit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumatic event ance.		19a. Informant's Name/Relationship Valerie E. Turpin/ D	aughter	4109	- · · · · · · · · · · · · · · · · · · ·	Lane, Rand	allstown,					
Dallillor permit. Pages 1 Department of H Important: If ite any injury or ot once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Content of the Content	20c. Location - City or Town, State Arbutus, MD									
permi Depa Impo	Ì,	22. Name and Address of Facility Wylie Fineral Hacme P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Pany. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
Physician /Medical Examiner pau- pat- pau- pau- pau- pau- pau- pau- pau- pau	Examiner	sh k, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque	nce of):	Yma	m bo.	r C		Approximate Interval Between Onset and Death			
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	léath 3 🗆	Ectopic pregnand Other (specify)	у		23d. Date of de Month	elivery Day Year			
quires that i	þ	Part II. Other significant conditions		e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏂 Unknown								
The law requires to cate has been signe page 2 should be o	Completed											
Physician: The Physician: The rithis certificate hrall director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 221No	Hospital: 1 ☐ Inpatient 2 ☐ E	th (Check only one) time 5 ☐ Residence 6 ★ Other (Speely)								
To the Hospital or Attending Physician 2 or the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Seath Natural 5 Pending investigati 3 Suicide 6 Could not determine	be 290 Place of Injury. At hom	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
h e Hospit . In 24 hours h e Funera pletely fille	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the til restigation, in my o	me, date and place opinion, death occur	, and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)			
To the within To the comp	Ň	29b. Signature and title of certifier	Bar	no	29c. Licens	e number	27 A	9d. Date signed (Mon	211/0			
		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, F	Print)	n' on	And	21	1269			
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	1 Sou	erkel		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician Fiora Yvonne Barnes MM 5010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) If Under 1 Year **Funeral** Months 1□ M 💥 F Days Hours Yrs. 213**-3**6-1891 9-11-1937 Director MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evanning Investible and Yes 2 □ No Director MD n/a **Baltimore** 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2218 Mt.Holly Street 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: specify: African-American ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12th File Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Matthew Scott Tinie Bowler ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health al
Important: If item 27 is
any injury or other trau 2218 Mt. Holly Street, Baltimore, MD 21216 Kimberly Barnes/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cametery 2-19-2010 Woodlawn, Mi 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Whie FuneralHome P.A. of Balto. Co. 9200 LibertyRoad, Randallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** acute on known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dulmonu MKnowy Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) signed by the aid be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe 2 No 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D47353 ess of posson who completed cause of death (Item 23a) (Type, Print) Avenue Bultmere, 30. Name and add

DHMH 17 Rev 1/2001

State Registrar Jan

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucille PEBRUARIT 4 Year 2010 5-12-AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BACTMORE WARHINGTON MEDICAL BURNIE ANNE ARUNDE ENTER GIEN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Month, Day, **Funeral** Country) Vivginia 1 🗆 M 2 📝 Months Days Hours Min 150-22-4616 Director Jan. Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Anne A Severa 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral UST Jacobs 1735 Meanow Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 ₩Widowed 4 □ Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Grove Elementary/Seconday (0-12) College (1-4 or 5+) Aide Dietar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henr **YerKins** Amie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Webster-danahter Jacob's Meadow Judy Drive Seven permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Metro Cremato tonsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addres of Facility cdenic Many 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Martite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Ves 25. Was case referred to medical examiner? funeral director, æ 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) Residence 6 \(\text{Dother} \) Other (Specify) Hospital: 2 No ျ 1 Tes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director. 2 Accident
3 Suicide
4 Homicide completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifle 29c. License numbe 29d. Date signed (Month, Day, Year) Mi 2010 Name and address of person w completed cause of death (Item 23a) (Type, Print) 30 MI) 20161 owner

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 16b & 19a G902 4/7/10 TT State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:32 A Physician/ Bernot Month D 2010 lizabett rebruat Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death LATA ENTER EDICH last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs 6606 1 🗆 M 2 👺 Months Hours (Month, Day, Y Pennsylvania Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location e filed within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Fran Del 8700 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black, White, etc. 1 Never Married 2 Married 2 No Yes 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Black 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Watts Tweed permit. Page 1 and 2 should f Health and Nitem 27 is ma 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 For Jefferson- Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pennsylvania White Chape 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) Month Day Year Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown after death.

Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: V No မ 1 Yes 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month. Day Year) completed cause of death (Item 23a) (Type, Print) Suite 207 Old Line Centre 12070 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

10-01031 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Wanda Renee Brown 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day February 4, 2010 Medical Examiner 1724 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1100 Bolton Street Apt. 511 **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Director 2 1 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 No Maryland tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 No 1 Yes Specify: Black Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. 4 Divorced If Yes, Give Year Yes 2 No specify 3 Widowed . Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Indust College (1-4 or 5+) Elementary/Secondary (0-12) Janitar 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wende Brown Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) BoHon item 27 is Mar 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Important: Cemeter 4 Donation 5 Other Specify. 22 Name and Address of Faci 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Cardiac Arrthythmia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical AMENDED 23a,pt.II,27 per me g901 3-25-10 vt X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ۵ 1 Yes 2 No 3 Probably 4 Unknown Schizophrenia, SNRI Use Completed certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other Scene ER/Outpatient 3 DOA After this 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending within 24 hours after death.

To the Funeral Director: the f 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Victor Weedn MD JD istrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ea

Assistant Medical Examiner

State Registrar

2 🗸

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anne Cothran Currie State of Maryland / Department of Health and Mental Hygiene 0 1 0 - For State Certificate of Death Reg. No Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day February 14, 2010 1418 hrs Medical Examiner Anne Cothran Currie Bouiti 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 8302 Philadelphia Road Rosedale 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Hours Min 218-70-8039 Months Days Director 52 January 29, 1958 Country) Maryland М 2X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Baltimore Rosedale 1 Yes 2 X No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene.
ant: If (item 77 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once Director 10e Street and Number 10f. Zip Code 10g_Citizen of What Country? United States 21237 8302 Philadelphia Road of America Funeral 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2X No Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 clerical Secretary 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Graves William Currie Be 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally C. Vuncannon/ sister 12417 Ocean Gateway Ocean City, Maryland 21842 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition February crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important: injury or oth Evans Funeral Chapel 17, 2010 Forest Hill, Maryland **Department** Donation 5 Other Specify 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Lic see 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Retween Onset and /Medical Death a Oxycodone, diazepam, citalopram and ethanol intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED # 1 X UNPENDED physician the burial as noted. 23a,27,28a-f,permE, g901 3/18/10 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown ed by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed death? Yes 2 V No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: å examiner? Hospital: 1 Inpatient 2 Other | Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA this 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No 5 Pendina Director: d in by the f after death Fd 2/14/10 Fd 2:10 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8302 Philadelphia Rosedale, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide found at residence (Specify) 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) Signature and title of certifier O.C.M.E. February 15, 2010 30 Mame and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #17 per FH g900 2/1//10 TT State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 11:45A M 2010 Juanita Bogdan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center Baltimore Towson 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Country)
Philippines 1 □ M 2 🕅 F Min. Director Yrs. 216-76-0372 79 1930 Nov Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at any Injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10108 Daventry Drive 21030 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Specify: Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 01 Assembly Worker Medical Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Paulino Cabardo Paulino Ca bardo Emeteria Corbillion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jocelyn Noel/Daughter 10108 Daventry Drive, Cockeysville, MD 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/15/I0 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 21. Signature of Funeral Sorrice 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, Maryland 21093 Michael 9. 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 20513 Medical Due to (or as a consequence of): **Examiner** LAMS anspere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi ightes Cause (Disease or linjury mellitys that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknow signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by distan 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an evacon 1005/h autopsy nerformed' death? 2 No 27 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **N**lo Other: 1 🗆 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation Could not be filled in by the 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical

State Registrar 29a. Certifier

(Check

Arm

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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701

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Towson

29d. Date signed (Month, Day, Year)

2010

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21204

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

N. Charles ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g900 2-19-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 15, 2010 OLIVER PORTER BOYER FEBRUARY 3:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6 Carolina Ave Bel Air If Under 1 Year Harford If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F Director 220-24-1433 81 APR. 4, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified a Directo 1 ☐ Yes Ž**O**No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 6 Carolina Ave USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, It we Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. by Funeral 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No IfYes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Vice President Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Porter Boyer Sr. Effie Louise Nelson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Quinn Boyer / Wife 6 Carolina Ave., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Durial 2 Cremation 3 Removal from State 21. State of Fune at the icensee 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 2-17-10 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. Mask 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Y inal disease or condition resulting in death) PERMONARY Physician 1 DIOPAMIC 6 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) death certificate be executed Exami burial-tran and Due to (or as a consequence of): Box 68760. attending physiciar Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Jo. Month Day Year signed by the a 5 ☐ Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No 24a. Was an autopsy performed? this certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check rly one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 NINO To the Hospital as construction within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral director. မ 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

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State

Registrar

31. Date filed (Month, Day, Year)

500 Upper Chesapeake Dr., Bel Air, Maryland 21014 32. Pegistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason Birnbaum, M.D.

W)

D0056296

16-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ rowk Month 2234 M Medical 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GIEN MIC Dur If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 🕅 M 2 🗆 F 220 70 0132 51 Months (Month, Day, Year) 03/16/1958 Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location be notified at **Funeral Director** 10d. Inside City Limits Caroline 1 🗆 Yes 2 🏝 No Maryland Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 North Central Avenue 21660 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or iter , the Medical Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Driver - Sales Keystone Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Calvin Eugene Brown Clara (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan Brown Jr. / Son 9014 Town & Country Blvd.Apt. A Ellicott City, MD. t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Page Department o Important: If any injury or Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 02/15/2010 Baltimore, Maryland 21. Signatura Filmeral Service Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year ate has been signed by the a page 2 should be detached f 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Completed 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 2 | No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Depu4 d cause of death (Item 23a) (Type, Print) Ĭ NEVICA Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle | Last) 2. Date of Death 3. Time of Death Physician/ ESTER MARIA BOGATYRYEV FEBRUARY 20Tb 7:14 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3601 FORDS LANE, #712 BALTIMORE N/A Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Hours 0172871922 Director 218-29-2396 88 UKRAINE Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3601 FORDS LANE, 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married <u>\$</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul may injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) TAILOR CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည JACOB GOLDBERG **GUSTAVA** SHTRAYCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMARA BOGAT / DAUGHTER-IN-LAW 2514 LIGHTFOOT DRIVE, PIKESVILLE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 2/16/2010 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 21. Sign ture of Funeral Service Licensee INC MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Duath Physician/ disease or condition anemia tound mounty Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No ed by the a g Unknown g 🗌 Unknown Division of Vital Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ cate has been signated bage 2 should b Completed 1 Yes 3 Probably 4 Unknown 2 700 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 5 Residence 6 Other (Specify, ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a Certifier within 24 hou

To the Fune

completed file Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brown Month Day Kelsey februa tolo Medical 4a. Facility Name (if not institution, give street and number)
Johns Hopkins Bayview Hesical Conter **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore City Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Age (In yrs. last birthday, 8. Date of Birth (Month, Day, ine 13) 1 DM 2 X F 219-41-0023 15 Months Days Hours Director Maryland 1994 June Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Harford Darlington 1 Tes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2377 Shuresville Rd 21034 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black White etc. 1 X Never Married 2 Married à 1 ☐ Yes If Yes, Give Maryland 21215-0036 72 hours after Specify: White 1 Tyes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Schooled Student At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Edward Brown Carrie Ann Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shit of Health a George Edward Brown / Father 2377 Shuresville Rd, Darlington, MD 21034 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Darlington, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite Date injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cemetery 2/19/2010 4 Donation 3 Other (Specify) Maryland 21. Signatury of Luceral St 22 Name and Address of Facility Tarring-Cargo Funeral Home, P. 333 S. Parke St. Aberdeen, MD any i 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final brain death Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner brain injury 7 days Sequentially list conditions, Examine Puinto (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events CENTRICATION APPROVED BY MEDICAL DIAMINER burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month 5 Other (specify) Day Year the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nulti-system organ failure (acute renal Completed 1 Yes 2 No 3 Probably 4 Unknown peen Acute respiratory distress syndrome 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? this certificate or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 X Yes 2 \(\subseteq \text{No} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) February \$ 106 Certificate: 28b. Time of injury 28d. Describe how injury occurred 28c. Injury at hin 24 hours after death. the Funeral Director: After High speed motor vokille collision Natural Accident 5 Pending 1 Yes 2 No 1700 Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Revadise Rd and I-85, Aborden completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition of the basis of examination and/or investigation, in my classical examination and/or investigation, in my control at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RE5-000 February 13 Zolo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 4940 Eastern Avenue Battimore, MD 21224 Abtin Khosravi

Registrar

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32. Registrar's Signature

ALLMED, M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FERNANDO VALENTINO SOSA CRUZ Month Physician/ 2:04 DM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMER MARING AUDINA MAKOMA Social Security Number 6, Sex 7. Age (In yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign San Miguel, Salv **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. Febrar 147 1979 Director Yrs 215-83-1689 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 😡 Yes 2 🗌 No <u>Maryland</u> Prince George's Adelphi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be n Funeral 72 hours after death with 20782 Salvador 8709 23 Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ğ 1 Never Married 2 ☐ Married Yes 21 No Specify: White Maryland 21215-0036 1 XYes 2 No Specify: Salvadorian If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE 6th Be permit. Page 1 and 2 should be filed beartment of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GILBERTO ARTURO SOSA ANA JULIA CRUZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $9014\ ETON\ RD\ SILVER\ SPRING$, MD 20901JORGE ARMANDO SOSA (Brother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. LoSation - Otylor Town State Cementerio San Antonio Feb/24/2010 San Antonio Silva 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Funerales Latinop, Inc Signature of Funeral Service Licensee 600 Kennedy ST, NW: washington, DC.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence) f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certificate has t autopsy 2 🗌 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) $\mathbf{B}_{\mathbf{e}}$ examiner? Hospital: 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
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Registrar

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gistrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A^{M} 9:28 February 2010 <u>Rose Marie Craft</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7004 Brentwood Avenue Dunda1k Baltimore Co. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XF Months Hours Min. Country) 212-46-5342 60 **Director** Marvland Sept. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Dunda1k Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 7004 Brentwood Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cecilia Cuzinski Frank Hinterberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John J. Craft (Husband) 7004 Brentwood Avenue Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/15/2010 Towson, Maryland Service Corp 21. Signature of uneral Service Licenses 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between Onset and Death immediate Cause Final Pnysician/ Due to (or as a consequence of): embol disease or condition Medical resulting in death) Examiner pulmenery hypertens Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury -transit Exami executed and that initiated events Due to (or as a consequence of) y physician ar resulting in death) Last Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No signed by the a 9 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. autopsy death? 2 X No I ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes 2 🔀 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗖 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

101

State Registrar 31. Date filed (Month, Day, Year) 32. Registr

Richard A Berg

Ruhard o Barg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

,40; S., te450; 10755 Fells Rd. LuPluville, 4d 21093

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			1 - State Registrar	State	of Marylar			nt of He te of D		Mental Hy	gien Reg. N					
			1. Decedent's Name (First, Middle, Last)									ay Year	3. Time of Death			
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1	Examiner 4a. Facility Name (If not institution, give street and number)								4b. City, Town, or Location of Death 4c. County of Death							
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	Director		218-32-2872]M 2√□F	74	Yrs.	Month	Days	Hours IVII	Oct. 2	3, 1	935 Mary	land			
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	how		10a. State 10b. County		10c. CI	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2\text{2}No			
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	e L	Funeral	11. Marital Status	Armed F	edent Ever in U orces?	J.S. 13.	Was Dec f Yes, sp	edent of His ecity Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Amer Black, White				
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			shock, or heart failure. List only o	ne cause on	each line.	in. Do not ent	01 (110 111				211031,		Interval Between Onset and Death			
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	thin (Mec	29b. Signature and title of certifier	and mai	nner stated.	-		9c. License	number		29d F	Date signed (Monti	, Dav. Year)			
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	YV		30. Name and address of person who c					4 . 4 .	13	HIECTILA		P 112 -	1157			
			MAHBOOB ASHRI 31. Date filed (Month, Day, Year)		Registrar's Sign		01211	TL M	7 5	WESTMIN	216	R,MD =	(1151			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 11, 2010 16:40 DONALD REYNOLDS CASSELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours 1 M M 2 □ F Months Days 15, 1925 Maryland Director 212-20-9360 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rral", or items 23a or 28a-f show Exeminer must be notified at 1 Tyes 2 XNo Funeral Director Maryland | Harford **Fallston** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 710 Old Fallston Road 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 ⊠ No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Road Construction Foreman Road Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Frank (nmn) Cassell Helen (nmn) Reynolds ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trauonce. Frank J. Cassell 20 Schoolhouse La., North East, MD 21901 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🗷 ¢remation Removal from State Other (Specify) Service Corp. 2-17-10 Towson, Maryland Hilltop 21. Signature of F. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Due to or as a consequence of): disease or condition resulting in death) nematomo /Medical THE REPORT OF WHITE A LANGE OF THE PROPERTY OF Examiner Sequentially list conflictus, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quantially list o or this as Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Dav Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ una cancer, Alzheimer's dementia, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed Coronary artery disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XYes 2 □ No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 | Natural 5 Pending Iniury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 X No investigation 2 Accident 3 Suicide

or Attending after death. Director: Af To the Hospital within 24 hours a To the Funeral D

Registrar

cal

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

710 Old Fallston Rd. Fallston, MO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0068014

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 500 Upper Chisapeake Dr. Bel Air, MD 21014

32. Repistrar's Signature Nasrin J. Hug 31. Date filed (Month, Day, Year)

6 Could not be determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only

Home

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Year James 8:39 AM February Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BON SECONAS Baltimone CIT Baltimore Huspital 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 8 Date of Birth **Funeral** 1 M 2 F Months Days (Month, Day, 220-22-615 Director MARWLand 10-1930 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No Md 10e. Street and Number 10g. Citizen of What Country? Funeral Ave USA NORMANDU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No BLack Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) WRIVER soach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carroll > Ames 19a. Informant's Name/Relationship (Type, Print) Daug Wee) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CareroLL Matthews 5400 IAME Gerl 20a. Method of Disposition 20b. Place of Disposition (Name of Cremation 3 ☐ Removal from State Burial 19/2010 DUSTING WITH 4 Donation 5 Other (Specify) 21. Signature of Funeral Name and Address of Facility or complications that caused the death. Do not enter the mode of dying, such as cardiac or respi List only one cause on each line. Part 1. Enter the dises Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical Cograial disease or condition resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performed' 2 🗌 No Yes 2 W 1 \square Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 2 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3010 1058771 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byllimon varience Kubinitu 2000 WEST Baltimore Street

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James T. Cherry Feb. 2010 11:40P[™] Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 812 Nat Ct. Apt.3 Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min. 216-504272 Director 60 Carolina Usual Residence of Decedent show 10a, State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director MD n/a 28a-f Baltimore 1X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 812 Nat Ct. Apt. 21212 USA Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Rotunda life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaners 12th <u>Shoe Repair</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abraham Singleton Georgia Cherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquline Cherry (wife) permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other troones. 812 Nat Ct. Apt.3 Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Feb.17,201 4 ☐ Donation 5 ☐ Other (Specify) Mount Crematory Green Baltimore, Md. of ature of Funeral Service Licenses 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Preston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostake Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death g ☐ Unknown Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 LX No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending 2 No Investigation Suicide 6 Could not be within 24 hours after d

To the Funeral Direct
completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

N.

32. Registrar's Signature

(halls

R149194

St. Towson

29d. Date signed (Month. Day, Year)

8,2010

February

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03885 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02/15/2010 Day Dorothy Rita Daneluzzi A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 613 Cape McKinsey Drive Severna Park Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🙀 F Days Hours Min Director 142-09-5123 90 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 K Yes 2 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21146 613 Cape McKinsey Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces "natural", or ğ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Hair Dresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Strano Concetta Catalano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Catherine M. Davis/Niece</u> <u>613 Cape McKinsey Drive,Severna Park, MD 21146</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If ite 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Services 02/17/2010 HANOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Ardent Cremation Services Connellev Drive Ste. Hanover. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ ORRBROVASC ULAR disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending p IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy in the past 12 mon Dav 5 Other (specify) Pregnant at time of death Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 🗌 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No nours after death. neral Director: Aft if filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 8601 Voiepus HIGHER Musesuus

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

10-01367 Vance Dickson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 03886 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death			,	F	Reg. No.		
Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year									3. Time of Death			
edical Examin		Vance Adlee Dickson February 15, 2010									0001 hrs			
2		University Hospital					Baltimo						unty of Dea	
Funeral	- 1	5. Social Security Number	6. Sex	7. Age (I	n yrs. last bir	thday)	If Under	1 Year Days	If Unde	_			Fore	Birthplace (State or eign
Director	Director 217–52–1692 1X M 2 F 60							Days	Hours	Will.	01/31	1/1950	0	Country) Pa.
<u> </u>	-	Usual Residence of Decedent 10a. State 10b. County		110	c. City, Town	or Locatio	n							10d. Inside City Limits
Maryland 28a-f show any d at once.	اة	Maryland Balti			Nottir									1 Yes 2 XNo
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Directo	10e. Street and Number 8504 Rhuddlan	Road				10f. Zip Ci	ode 1236	5			10g. Citizen o		puntry?
with the same se noti		11. Marital Status	12. Was De		er in U.S.						ecify Yes or N			erican Indian, Black,
death or iten	Funeral	1 Never Married 2 X N	1 Yes	2 X	No					Puerto F	Rican, etc.)		White, etc.	
s after ral",	ᇍ	3 Widowed 4 Di	vorced If Yes, Give Ye or Dates:		ted) Itee	1 Decedent	Yes 2 X			rind of un	ark dogo		cify: Wh	
hour "natu	달	Elementary/Secondary (0-12)		1-4 or 5+)		during mo						IOD. KIIIG	or busines	s/Industry
hin 72 e. than	Completed	Elomonially/0000maily (0 12)	4	, , 0, 0 . ,		canspo	orter	Dri	iver			Ste	el Mi	11
5-0036 iled within 7. Hygiene. I other than	탉	17. Father's Name (First, Middle	e, Last)					18	3.Mother	s Name (First, Middle,	Maiden Surn	name)	
218 be fill intal F rked	å	John R. Dickso							aura			affer	× .	
D 21 hould nd Me is man]∟	19a. Informant's Name/Relation			1			•						nte, Zip Code) ad 21236
MD and 2 sho salth and em 27 is raumati	ŀ	Patricia Dicks 20a. Method of Disposition	OII (MITE)		20b. Place					, INC	Date			or Town, State
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Injury or other tr		1 X Burial 2 Crematio	n 3 Removal f	rom State	crema	tory or othe	er place)		· ·	22/4				
tin Pagintiment	-	4 Donation 5 Other S			HOTT						7/2010			e, Maryland
Bal permi Depa Impo injur	7	21. Signature of Furieral pervice	Licensee			1/1	07 Ol	Bruz	zdžii	nski	Funer	al Hom	e, P.	A. ryland 21221
Physician		23a. Part Lenter the disease, o	r complications that	caused the	e death. Do n	ot enter the	e mode of o	dying, su	uch as ca	ardiac or	respiratory ar	rest, shock, o	or heart	Approximate Interval Between Onset and
/Medical	1	failure. List only one cause	A 4 . 141 . 1 - 1	juries										Death
Examiner	1	er condition resulting in death)	Due to (or as		ence of):									
	۱.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequ	ence of):				<u>-</u>					
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	C.				•							
J. p Its		events resulting in death) Last	Due to (or as	a consequ	ence of):									
760, cate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED											
760, icate be physici the buri	<u>ĕ</u> ŀ	IF FEMALE:	23c. If yes,	outcome	of pregnancy							23d. Da	ite of delive	ery
687 sertific tding p		23b. Was decedent pregnant in t past 12 months?	LIVE		6 -141-	- =	al death	_	Ectopic	pregnan	icy	Mon	nth	Day Year
Box 68' e death certifi	ซิโ	1 Yes 2 No 9 Ur	nknown 9 Unkr		io or dodar	5 Oth	er (Specif)	')						
O. Bat the d		Part II. Other significant condi	tions contributing	to death bu	ut not resultin	ng in the un	derlying ca	ause giv	en in Pa	rt I.				to the cause of death?
ires that isigned by the detact	<u>و</u>										1 Ye	s 2 🗸 No	3 Pr	obably 4 Unknown
rds requi	흥										24a. Was			autopsy findings available completion of cause of
he law ate has age 2 sl	Completed											ormed? 2 ✔ No	death?	Yes 2 No
tal Rec	ည် ကို	25. Was case referred to medica					26.		of Death (Check o	nly one)			
Vit hysici this c	의	examiner? 1 ✓ Yes 2 No		Inpatient		utpatient					Home 5	Residence		ner:
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	tion:		idirig	e of Injury h, Day Year , 2010) 28b. 094	Time of Inj	·	_ `	at Work		28d. Describe Subject fell		ccurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Cou	ila not be		y - At home, f	arm, street	, factory, o	ffice bui	ilding, etc		or Town,	State)		Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier	Physician: To the be		trial Area	eath occurre	ed at the til	ne date	e and pla		- 			Sparrows Point, MD ated
To the Hos within 24 h To the Fur completely	Medical	Check only	aminer: On the basis and manner	of examin										
F > F 3	Ž	29b Signature and title of certification	1						number					fonth, Day, Year)
		hig a	~ , m	,			(D.C.M	I.E.			Februa	ry 16, 20	J10
15		30. Name and address of perso Ling Li, MD Assista	n who completed cau ant Medical Exa		th (Item 23a) 111 Pen	n Street	Baltim	ore M	ID 212	01				
Sta	ite	31 Date filed (Month, Day, Year,	32. F	gistrar's		5.1001	.,	- · - · , 181						
Registr	_	FEB 1	7 2010	ineva	1.	bar	del							
DHMH 17 Rev 1/20 OCME 2006	01		#		OF	RIGINAL					OCME			

10-01373 Harry Dillow Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 15, 2010 0919 hrs Harry Maurice Dillow **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford **Bel Air** 302-A Canterbury Way If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Months Days Hours Director Country)Maryland 1 X M 201-10-8753 2 F 89 Yrs March 13,1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. MD. Harford BelAir permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 A Canterbury Rd. 21014 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes If Yes, Give Year 1944-1946 1 Yes 2 X No specify: White 3 Widowed 4 Divorced ð or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other than ' 12 4 Electrical Engineer Bell Labs Compl 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Dillow <u>Katherine Keatts</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt: If item 27 is n other traumatic . Md Barbara A. Hughes <u>4202 Piney Park Rd.</u> <u>Perry</u> Hall 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition ltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 3-1-2010 Owings Mills, Md 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service tricensee Schimunek Funeral Home Nottingham, Md. 21236 駋 9705 Belair Rd. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi Records, P.O. Box 68760,
The law requires that the death certificate be executed sician/Medical **AMENDED** UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ð Completed Records, certificate has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA After this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Division 1 Yes 2 No Pending Director: ţ Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide within 24 hours a To the Funeral I. Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 16, 2010 O.C.M.E. buthall, MA 30. Name and appress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 02 - 16 - 2010 0458 Peter Darling 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-08-1964 Birthplace (State or Foreign Country)
 C 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 X M 2 □ F 45 105-62-2247 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21 Swan Street 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attendant Gas Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gregory Darling (Father) Arlene Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11701 Popes Head Rd FAirfax, VA Gregory Darling (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bavview Crematory 02-17-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a sonsequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

/Medical Examiner Ō certificate be executed 9 68760, the the The law requires that the death signed by Records, certificate Vital To the Hospital or Attending Physician: ō After this Division illed in by the fu

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

MD

ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, Its Modical Exaction must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "r any Injury or other traumatic event. If Item 1000 to the traumatic event.

Physician

 $58 \quad M80037$ Baltimore, Maryland 2

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown

1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

29a. Certifier Certifying Physician: To the best of my best of ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ner: On the basis amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many stated. (Check only one) 29d. Date_signed (Month, Day, Year) 29b. Signature and title 29c. License number

State Registrar

31. Date filed (Month,

Day, Year)

ORIGINAL

Registrar's Signature

within 24 hours a

Box 68760 P.O. Division of Vital Records,

21215-0036

Maryland

Baltimore,

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRNP K176874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mudeluine Binner, DNP, CRNP 5KCCC SKCCL DJHBMC 5505 Hopkins Baynew Cire 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 17 2010 parks

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Amanda Eleanor Drain 2 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deati Examiner inty of Death . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Min. (Month, Day, Year) Country) 085-18-0037 87 Director NY ept 1922 Usual Residence of Decedent or 28a-f show 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Catonsville MD 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 709 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 6 2 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural" Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Liberatus Kilian Amanada Krause other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Elise Kilian / Niece 42 Gorsuch Road, Timonium, MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a, Method of Disposition 20c. Location - City or Town, State Department of Important; If 1 Durial 2 Cremation 3 Removal from State injury or 2/17/2010 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License Corota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD - Ma Mons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Ho Pregnant at time of death 5 Other (specify) Month Day Year sate has been signed by the a page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 110 Other: 1 Yes 은 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ :30 GM Margaret Pauline Dean 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Home av fol NUSSIG Haure Grac 1112815 1) . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 1 □ M 2 😾 F 82 J(Marth, D211 Year) 1927 Mary Land 215-24-8805 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Aberdeen Harford 1 ☐ Yes 2 X No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō rral", or items 23a o Examiner must be Funeral 21001 3618 Churchville Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: SpecifyWhite If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Technition Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anna Elasewich Martin Golladay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Churchville Rd, Aberdeen, MD 21001 Stephen P. Bilka III / son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State st.Paul s Cemetery Aberdeen, Maryland 2/19/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furer 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, winun disease or condition resulting in death) Medical Due to (or as a conse uence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Year Pregnant at time of death 1 Yes 2 No completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?

1 Yes 2 No Division of Vital Certificate: To Be 25. Was case referred to edical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending 2 Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wish 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 407 31. Date filed Month, Day, Year) 🕉 32. Registrar's Signatu State FEB 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:15 Рм Bonnie Lee Doane 12 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/27/1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Vear Days Months Hours 217-36-4671 87 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, It e Medical Examinant on other traumatic event, It e Medical Examination 1 □Yes 2 □ No Director Maryland | Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 USA 239 Poclain Rd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Assembly Line Labor 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Holmes Joseph Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1821 Mitchell Dr, Aberdeen, MD 21001 Connie Rimel / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Aberdeen, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem Gdns. 2/17/2010 4 Donation 5 Other (Specify) Maryland 21. Signature of Funeral Sery ce Licensee 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A Tarring-Cargo Funeral Home, 333 S. Parke St, Aberdeen, M

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>333 S. Parké St. Aberdeen, MD 21001</u> Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FASCIITIS NECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner nding physician and ise as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 □Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records,

Hospital or Attending within 24 hours after dea To the Funeral Director completely filled in by th

or 28a-f show

Maryland 21215-0036

Baltimore,

Pages 1

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Name and address of person who completed cause of death (Item 23a) (Type, Print) AWALA, MD

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** me 2010 /Medical 4a. Facility Name (If not institution, give street and number, City, Town or Location of Death 4c. County of Death **Examiner** MOP Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) - 19 **Funeral** Months Days Hours Min. 1 □ M 2√2 F Yrs NC Director 220-64-8658 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It a Mail Call Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Directo MD Baltimore City City Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 Funeral 4303 Plainfield Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ 3 Widowed 4 Divorced Black Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u> Annie Mae Cornwell</u> ပ James Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Jacqueline Cornwell/Sister</u> 4303 Plainfield Avenue, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Gremation Services | 02/17/2010 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Se e Lice 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** esophageal cancer months disease or condition resulting in death) 7Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical for use IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Dav Year 5 Other (specify) the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate 1 □Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. after death filled in by the

24 hours a completely within 2 V

State

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Broadway

and manner stated.

2 MA my

401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Juergens, w

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

60203

29d. Date signed (Month, Day, Year)

16,2010

1-ebruary

Johns Hopkins Baltimore Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}4, February 2010 Charles Gerhard Eser 12:00P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 660 Americana Drive # 13 Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 D F Months Days Hours Min. 1 Month, Pay 1 9 9 Marviland **Director** 213-16-9400 90 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? Funeral 660 Americana Drive Apt. #13 21403 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ✓ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 🔀 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed WWII White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>District Sales Manager</u> <u>General Electric</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gerhard Henry Caroline Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dana Hunt - Daughter 108 Simonds Road Lexington, MA 02420 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood_Cemetery 02-18-2010 Baltimore, Maryland 21. Signa / r + f Funeral 5 lice Ligensee Towson, Maryland 21204 22, Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ca ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Interval Between Onset and Death Immediate Cause (Final Physician ATHEROSCLERDTIC disease or condition CEREBROVASCULAR Medical resulting in death) Due to (or as a consequence of) ⁴Examiner DEMENTIA VASCUL ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Exami DISEASE cate has been signed by the attending physician and page 2 should be detached for use as the burial-transity CORONARY ARTERY that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ATRIAL FIBRILLATION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Carotial Sterosis DEPRESSION autopsy Hospital or Attending Physician: The l 24 hours after death.
 Funeral Director: After this certificate h performed? Yes 2 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospital 1 ☐ Yes 20 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D31997

State

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Charl

Registra

32. Registrar's Signature

2003 Medico (Phwy St 100 ANNAPOLIS,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDROW GORDON

31. Date FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

acı	e Estevez		1- For State	te of Maryla		artment of rtificate of		and	Menta	al Hy	giene	20		03895	
	Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Anoth Day Yes											3. Time of Death	
edi	ical Exami		Tracie Lynn Est 4a. Facility Name (if not institution,	evez							Month February			2239 hrs	
			4a. Facility Name (if not institution, Upper Chesapeake Me		imber)	41	o. City, To Bel Air	wn, or Lo	ocation of	Death	4c. County of Dea Harford				
	Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/DD/YYYY			
	Director		217-98-8673	1_M 2XF		42 Yrs.	Months	Days	Hours	Min.	June 4	, 1967	Foreig Co	untry) Maryland	
	any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locatio	in .							10d. Inside City Limits	
		_	Margiland Harford Edgerrood										1 Yes 2 No		
	Maryland 28a-f show d at once.	Director	10e. Street and Number								1	0g. Citizen of Wh	- 4.4		
	with the Maryland ms 23a or 28a-f sho be notified at once.		2826 Beckon Drive 21040												
	215-0036 be filed within 72 hours after death with the Maryland nall Hygiene. red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Mari		cedent Ever in U. orces?						cify Yes or No lican, etc.)	- 14. Race White		can Indian, Black,	
	ter dea ", or it er mus			1 Yes	2 X No	1 .	Yes 2	No	specify:			Specify:	T.Tle	:	
	2 hours afte "natural", Examiner	d by	15. Decedent's Education (Specif	or Dates:		16a. Decedent	s Usual D	ccupation	n (Give kir				Sb. Kind of Business/Industry		
•	n 72 he lan "n ical Ex	olete	Elementary/Secondary (0-12)	College (1	College (1-4 or 5+) during most of working life. DO NOT use retired)										
Š	-003 4 withi rgiene. ther th	Completed	17. Father's Name (First, Middle, L	ast)	2	Admir	nistr					Medic Maiden Surname)			
2	21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Delano Ha	,											
	21 should nd Mei is mai	ဥ	19a. Informant's Name/Relationshi	p (Type, Print)								nber, City or Town			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours all peptriment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		Ralph Estevez / Spouse 2826 Beckon Drive, Edgewood, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - C										nd, City or	21040 Town, State	
	ages 1 nt of H t: If it		1 Burial 2 Cremation		rom State	crematory or other	er place)			0 / 0 0	/2010				
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_	Physician /Medical		23a. Part I. Emer the sease, or confailure. List only and cause or	n each line.)	6		dying, su	uch as car	diac or i	respiratory arr	est, shock, or hea	art	Approximate Interval Between Onset and	
	caminer	Pericardial Hemorrhage and Tamponade											Death		
			Sequentially list conditions,	b. Ruptured M	/lyocardial In	farction									
		nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c. Atheroscler	consequence or rotic Cardiov	· ·	ase								
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	certificate be executed certificate by executed and certificate by executed and certificate as the burial - transit	edical	UNPENDED	a. AMENDED											
	760, cate be physical		IF FEMALE:	23c. If yes,	outcome of preg	nancy						23d. Date of	delivery		
Ċ	Box 68760, e death certificate be the attending physic ed for use as the bur	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth nant at time of de		il death er (Specif	3 _	Ectopic p	regnan	су	Month	[Day Year	
Č	BOX te death the atte	Physician/N	1 Yes 2 No 9 V Unknown	9 Unkno	own	3 [_] Oth	er (Specii	" <u> </u>							
	ires that the de right of the de right of the de detached to	by P	Part II. Other significant condition	ns contributing to	o death but not re	esulting in the un	derlying c	ause giv	en in Part	l.			_	the cause of death?	
	dS, Fouries squires ulid be										24a. Was			topsy findings available	
	COT law re has be e 2 sho	Completed					 	_			autop perfo	psy p rmed? d	rior to c eath?	ompletion of cause of	
Ċ	Vital Records, ysician: The law requirent this certificate has been a director, page 2 should		25. Was case referred to medical	Т			26	Place of	f Death (C	heck or	1 Yes	2 No 1	✓ Ye	s 2 No	
7,7	Vita hysicia this ce al direct	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		10	thor:			Residence 6	Other	,	
4	After funera		27, Manner of Death 1 ✓ Natural 5 Pandin	28a. Date (Month	of Injury ı, Day,Year)	28b. Time of Inj	· 1	_	at Work?		8d. Describe	how injury occurre	ed		
	SiOr Attenc r death ector: by the	catio	2 Accident Investi	gation 28e Plac	e of Injury - At h	ome farm street			s 2 N	_	Rf Location (Street and Number	r or Ru	ral Route Number City	
24a. Was an autopsy performed? 1									i oi ita	rai reduce reamber, only					
	Hospital 24 hours. Funeral etely fillec	Sa	29a. Certifier 1 Certifying Phy	sician: To the bes											
	To the within To the comple	Medical	one) 2 Medical Exam	iner:On the basis of and manner s	of examination a tated	and/or investigatio				irred at	the time, date				
1	29c. License number 29d. Date signed (
	7 ,	1	30. Name and address of poon w	ho compled caus	se of death (Item	r 23a)							,		
	61	3	Russell Alexand MD.	Assistant M	Aedical Exan	444	enn St	reet, B	Baltimor	e, MD	21201				
	St Regis	ate	31. Date filed (Month, (La) (Pear)	2010 32. P	evistrar's Signatu	ures.	1/40								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1237AM Thedford Flemina Februar 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 629 BALTIMORE DUMBARTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 02-05-**Funeral** 1 M 2 - F 83 Months VIRGINIA Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be notified at MD BALTIMORE 1 Yes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? DUMBARTON AVENUE USA s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. GOV'T Elementary/Secondary (0-12) College (1-4or 5+) ARMY INFANTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BOOKER မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PASADENA, MD. 21122 RD. FLEMING SON permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 118/2010 ARLINGTON, VA ARLINGTON CEMETER 4 Donation 5 Dother (Specify) 21. Signaturi of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCVS ROAD. BALTIMORE, MD. 21212 NUG1553 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonar Obstructure Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to for as a consemence our signed by the attending physician and d be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, this certificate has been sign al director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar R110361

in hom CANP

20 0 September 20 0 S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LVb

29d. Date signed (Month, Day, Year)

Loch Raven Blvd Baltimore, MD 21218

11 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Daniel French Jr. 2010 9: DO A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XX M 2 □ F Months Days Hours Min (Month, Day, Year) 11/06/1959 Virginia 219 80 7199 50 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Pasadena Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be 1 once. Funeral 21122 573 A Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Welder / Fabricator Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John D. French Sr. Carol Keener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonva French / Wife 573 A Street Pasadena, Maryland 21122 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 02/09/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemeterv 21. Signature of Eurieral Service Licens Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the bath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Acus Eren CEREBONOVESCI Physician/ disease or condition resulting in death) Acute Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the should be detached 9 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy perfor death? certificate I 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending Natural 1 Yes s after death. Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital 24 hours completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard 2:32 AM Charles Foster, Sr. February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1118 Gypsy Lane W Towson 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Months Days Hours (Month, Day, Year) Director Maryland 219-32-6864 lan Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1118 Gypsy Lane W 21286 U.S.A. 11. Marital Status 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗓 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Vice-President Import/Export Business permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foster, Sr. George D. Alice Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilynn B. Foster 1118 Gypsy Lane W Towson, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-2010 Hilltop Service Corp: Towson Maryland Signature of Fureral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Maryland 21204 Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) RODEN Medical Due to (or as a consequence of): Examiner -monAR Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and is the burial-transit or Attending Physician: The law requires that the death certificate be executed 2 CROATE C that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate ☐ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d, Date signed (Month, Day, Year) 4456

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DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wallace Pau1 4:00 A Forrest February 201 Medical Examiner 4a. Facility Name (if not institution. et and number) or Location of Death 4b. City, Tow 4c. County of Death If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign -88 1 XM 2 □ F Months (Month, Day Country) Marvland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1249 Balfour Drive 21012 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 1 Yes 2 No Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A <u>Self Employed</u> Building Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert Forrest Rose Brandhuber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen C. Forrest (Wife) 21012 249 Balfour Drive Arnold, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Pk. 02/16/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CCully—Polyniak F 3204 Mountain Road Funeral Home, P.A. ad Pasadena, Maryland 21122 2/1 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of: Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 2 No detached 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an After this certificate has autopsy Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

29b. Signature and title of certifie

1509

31. Date filed (Month, Day, Year)

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

32. Regi

DHMH 17 Rev 7/2009

mold

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DO056088

29d. Date signed (Month. Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:05A Frank Marie C. Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie <u>Baltimore-Washington Medical Center</u> Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Months Hours Min. Month, Day Year 1914 Mary Land Director 213-20-8642 95 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f sho amportant: If item 25 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 1543 Hodges Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 🗓 No Specify: 3 🕅 Widowed 4 🗆 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foster Handschuh Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1543 Hodges Avenue Glen Burnie, MD 21060 Howard L. Frank (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 02/16/10 Glen Burnie, Maryland A Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Fune at Service Licensee Dat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final nmom Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director, After this certificate to completed filled in by the funeral director, page

29a, Certifier 29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

2010

who completed cause of death (Item 23a) (Type, Print)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Month Pay 14, 2010 | 4c. County of Death **Physician** 1.35 AM /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** None If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct 23,1937 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 72 Yrs. 6 Sex **Funeral X**X M 2 □ F 242-54-6488 North Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XX es 2 No Director Maryland None Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1917 Fairbank Road 21209 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" — any injury or other traumatic exercition. 12. Was Decedent Ever in U.S. Armed Forces?

X X Yes 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 X Married 1 ☐ Yes XX No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales/Estimator Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Douglas Faircloth Sr Juanita Sawyer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Ann Faircloth Wife 1917 Fairbank Road Baltimore, Maryland 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State Crestlawn Mem Park Feb 19,2010 Sykesville, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility it chell-Wiedefeld Funeral Home Inc gnature of Funeral S 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or comp cause on each line Immediate Cause (Final UROSEPSIS **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Box 68760, ding physiciar Physician/Medical as the IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Division of Vital Records, 1 TYes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ည this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral Certification: 5 Pending investigation **Natural** Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

RAJANI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

(check only

TAGANA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

MD

and manner stated.

2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 per MD 18 & 19a, per Inf G902 4/2/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ramon Ricardo Guerrero Guevara **Physician** RAMON GUERRERO February 8:07Am^M 2010 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE"S Laurel Regional Hospital Laurel 9. Birthplace (State or Foreign El Salvador If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 69 Director April25. 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1. Yes 2 □ No r than "natural", or items 23a or 28a-f slife Wedical Examinar must be notified Director Maryland | Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 14106 OAKPOINTE Dr. El Salvador Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 🔼 No , or ! 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1₺ Yes 2 🗆 No Specify: Salvadorian Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A 6th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Beatriz Antonia Guevara Be Daniel Cipriano Guerrero ပ 19a Informant's Name/Relationship (Type. Print)
Sonia Duenas
Zonia Duenas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20707 14106 OAKPOINTE DR. LAUREL. (daughter) Maryland 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State General de San Miguel Feb/27/2010 San Miguel, El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa CRUZ Funerales Latinos, Inc 21. Signature of Funeral Service Licensee 600 Kennedy ST, NW:Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO RESPIRATORY ARREST Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPOGLYCEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit HYPERTENSION resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached fo P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Ś HYPOGLYCEMIA 1 ☐ Yes 2 No 3 ☐ Probably 4 X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an certificate has birector, page 2 s autopsy performed? 1 ☐Yes 2 🖾 No 1 □Yes 2 X No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

SUKHJIT SIDHU, 31. Date filed (Month, Day, Year)

30. Name and address of person who dom

29b. Signature and title of certifier

32. Regisar's Signature

eted cause of death (Item 23a) (Type, Print)

Laurel Regional Hospital, Emergency Dept

29c. License number

29d. Date signed (Month, Day, Year)

Wan Dusen Road

MD 20707

7300

Laurel,

Carmle Green 02/04/2010 1045 AM Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

29a. Certifier (Check only one)

Director

Funeral

Completed by

Be (၉

Examiner

Physician

/Medical

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

5	Please T	ype or Prin AMEND ITE State of Ma	t in Blac M#26per	k Ind PHY Depa	delible lnk. S. G900, 2 artment of F	Ensure Al /17/2010	II Copies WS Iental Hy	Are aiene	Legible.			
1 - State Registrar			,		tificate of			Reg. No.	0010	02003		
	ne (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death		
	Anne Green				41 O' T	1	Februa			10:45A M		
	If not institution, give s					r Location of Death		4C.	County of Dea			
5. Social Security N	on Ct. Apt		e (In yrs. last bir	rthday)	Nottin If Under 1 Year	igham If Under 24 Hrs.	8. Date of Bir	th		Ito. Birthplace (State or Foreign		
218-36-03	309 1□	M 2 X F		Yrs.	Months Days	Hours Min.	July 2	ay, Year)	Co	w York		
10a. State	Residence of Decedent ate 10b. County 10c. City, Town or Location									10d. Inside City Limits		
Md.	Balto.									1 ☐ Yes 2X No		
10e. Street and Nu	mber				10f. Zip Code			10g. Citi	zen of What Co	ountry?		
3 Fallo	on Court A	pt.A			21	1236			USA			
11. Marital Status		12. Was Decedent I Armed Forces?	er in U.S.	13. \	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No)-	14. Race - Ame Black, Whit			
1 Never Marr	ried 2 Married	1 ☐ Yes 2☐X	lo	1	1 □ Yes 2√□ No	Specify:	Tildan, etc.)			hite		
3 ☐ Widowed	4 ☐ Divorced	Year or Dates:			Thes A	Specify.			Specify: W	nite		
(Spec	15. Decedent's Educify only highest grade			. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired	eation during most of work d)	ing	16b. Ki	nd of Business	/Industry		
12				Home	emaker					me		
	(First, Middle, Last)					18. Mother's Name			,			
Laurent			T				thy McF					
	ame/Relationship (Ty) F. Green				-	and Number or Run Apt.A No				<u>.</u>		
20a. Method of Disp	•		20b. Place of	f Dispo	sition (Name of natory or other plac	Te) [Date	20c. Lo	cation - City or	Town, State		
	☐ Cremation 3 ☐ R 5 ☐ Other (Specify)	emoval from State			of Faith	2-9-2	2010	Balt	o. Md.	21206		
	uneral Service License	ee .	Garac		2. Name and Addre				Funeral			
1	C(1)			Ш	9705 Bela	air Rd. N			Md. 21			
23a. Part1. Enter t	the disease, or compli	cations that caused	the death. Do							Approximate		
Immediate Cause disease or condition		A A	ری معد (ج	2	tic Care	iovaso	[aplus	150	osp	Interval Between Onset and Death		
resulting in death)		Due to (or as	a consequence	of):	110 0001			T. Jane				
Sequentially list co if any, leading to in cause. Enter Unde	onditions, b	Due to (or as	i Curisequetice	υŤj.								
cause. Enter Under Cause (Disease or that initiated events	injury											
resulting in death)		Due to (or as	a consequence	of):								
		ı										
IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	pronths?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of de Month	livery Day Year		
Part II. Other sign!	ficant conditions cor	ntributing to death bu	ıt not resulting ir	n the ur	nderlying cause giv	en in Part I.	23e. Did t	tobacco u	use contribute to	the cause of death?		
							10	Yes 2	□No 3□P	robably 🖟 Unknown		
							24a. Was auto perfo 1□ Yes		prior to death?	utopsy findings available completion of cause of		
25. Was case refer examiner?	_					26. Place of Death	h <i>(Ch</i> eck o <i>nly</i> o	one)				
1 Yes 2	l No	lospital: 1 Inpatie	nt 25 EP /Ou	utpatien	t 3 DOA Oth	er: 4 ☐ Nursing Ho	me 5 Resi	idence	6 □Other (Spe	ecify)		
27. anner of Deat 1 Natural 2 Accident	th 5 □ Pending investigation	28a. Date of Inju (Month, Day		Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how injur	y occurred			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubulding, etc.	ry - At home, fa :. (Specify)	arm, str	eet, factory, office		28f. Location (City or To	Street an wn, State	d Number or R	ural Route Number,		

signed by the attending physician and dbe detached for use as the burial-transit The law requires that the death certificate be executed peen : within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: To the Hospital or Attending Physician:

Completed by Physician/Medical Be မ Medical Certification:

State Registrar

30. Name and address of person

29b. Signature and the of certifier

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature

31. Date filed (Month, Day, Year) FEB 1 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #14, per Fb C900 2/23/10 TT Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 710 DM aymond uniou Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Medican timor MOY If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min (Month, Day, Year Director North Carolin 216-50-4918 anuary Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Md. Harford Edgewood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1820 Larch Drive 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. **Black** Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Beth. Steel (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator Sparrows Point Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should re to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic examples. Budd Grant Melinda Jeffries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood, Md. 21040 Barbara Carter Sister 1820 Larch Drive Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Bayview 2-15-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Cances disease or condition resulting in death) MAG Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No 24a. Was an autopsy
performed?

Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2/10/2010 40 AU4176435614740

DHMH 17 Rev 7/2009

State

Registrar

30. Name and addr

31. Date filed (Month, Day, Year,

10 N Gruse

ack

Baltimore

MD

21201

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10

Lanton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State		State of M	aryland .	-	artment d <i>tificate d</i>			_		0010	02005
			Registrar 1. Decedent's Name		,			incare c	or Death		2. Date of De	_	6010	3. Time of Death
	ysicia Medic			17.	Kelso Guc	hemand	l 			_	Feb.	15		6:40 P.M
E	kamin	er	4a. Facility Name (if Gilchrist		e street and number) Center			4b. City, Tow	n, or Locati TOWS				County of Death	
Fur	neral		5. Social Security N	umber 6.5	Sex 7 Ag	e (In yrs. last i	birthday)	If Under 1 Y		der 24 Hrs.	8. Date of Bir	th.	Q Birth	
Dire	ector		413-64-77 Usual Residence of	75	I □ M 2 1 F	70	Yrs.	Months Da	ays Hou	rs IVIIII.	Sept. 2	7,19	39 Knox	hplace (State or Foreign Intry) Wille, TN.
and	at	Į.	10a. State	10b. County		10c. City, To	own or Loc	cation						10d. Inside City Limits
Maryland 28a-f show	otifie	.≐ ∟	Maryland				1X Yes 2 □ No							
with the	ust be n	_	10e. Street and Nur 2711 Gler					10f. Zip Co	2121	5	į		itizen of What Cou nited Sta	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If them 27 is marked other than "natural", or items 23a or 28a-f sho	Examiner n	þ	11. Marital Status1 Never Marr3 Widowed	ied 2 X Married 4 Divorced	12. Was Decedent 6 Armed Forces?, 1 Yes 2 If Yes, Give Year or Dates.	ver in U.S. No	11	Vas Decedent f Yes, specify (Cuban, Mex	ican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
Maryland 21215-0036 2 should be filed within 72 hours after this and Mental Hygiene. 27 is marked other than "natural", or	e Medica	Completed	Elementary/Sec	15. Decedent's l ecify only highest g onday (0-12)	rade completed) College (1-4 or 5	-	(Give I life. D	lent's Usual Od kind of work do O NOT use reti Cal Mus	one during r red)		ing	16b. I	Vocal M Educat	<i>l</i> usic
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Marylanc should be file and Mental F	tic ev		Edwin Kel	lso		_					M. Kels		· · · · · · · · · · · · · · · · · · ·	
Man; should and I	raum		19a. Informant's Na			1.		_					r Town, State, Zip	
and 2 Health	other t		Mr. Jerry 20a. Method of Disp		Guchemand	(Hus.)	e of Dispo	11 Gler sition (Name o	f		ltimore Date	<u> </u>	Location - City or	21215 Town, State
Page Tent of	ry or			Cremation 3 5 Other (Spec	Removal from State		-	natory or other eral Ch		Feb 20	^{Date} 18,			l, Maryland
Baltimore, permit. Page 1 and Department of Hea	any inju		21. Signature of Fu	peral Service Liver	Jeffrey L.	Gair,S	1 + 4	Name and Accepted A	dress of Fa Alterna k Road		uneral & nium, Mar	Cren	ation Cent	
Physic	cian/		Immediate Cause	(Final	plications that caused one cause on each line	the death. D	o not ente	er the mode of						Approximate Interval Between Onset and Death
	dical		disease or condition resulting in death)	on C	a. Due to (or as			~						years
T.	ij	Examiner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate rlying	b. Due to (or as	a consequent	ce of):							
760 cate be executed physician and	the bunal-transit		that initiated event resulting in death)	S	c. Due to (or as	a consequent	ce of):							
760 cate be	the bu	edical			d									
Box 687 death certific	hed for use as	Σ	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 0 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 🗌	Ectopic preg Other (specif					23d. Date of deli	very Day Year
S, P,O, res that the signed by	l be detac	by	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting	ng in the u	nderlying caus	e given in F	Part I.				the cause of death?
ords requii	should	lete									24a. Was		24b. Were auto	opsy findings available
Rec The lav	page 2	Completed									autoj perfo	psy ormed? 2 X N		ompletion of cause of
tal ician:	ector,	Be	25. Was case referr examiner?		Hospital:				Othor:	Death (Chec	k only one)			86 5
ing Physic	funeral dir	ate: To	1 ☐ Yes 2. 27. Manner of Deat 1 🔏 Natural	h 5 Pending	1 Inpati 28a. Date of inju (Month, Da	ent 2 ER. ry 281 <i>y, Year)</i>	Outpatier b. Time of injury	28c.	Injury at work?		ome 5 Resident		6 🔀 Other (Special ry occurred	m Hospice
Division of Vital Records, P.O. intelligence of Attending Physician: The law requires that the ust after death.	in by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not determined	be 200 Place of Init		, farm, stre			2 LI NO	28f. Location (S City or Tow		nd Number or Rura e)	al Route Number,
Hospital 24 hours	leted fillec	Medical	(Check 2	Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination an	d/or invest	igation, in my o	pinion, deat	th occurred a	t the time, date a	and place	e, and due to the ca	ause(s) and manner stated.
To the To the	сошо	2	29b. Signature and	title of certifier	_	200t Of High Kill	omouge, (29c. Lic	ense numb	er	so, and due to th	29d. Da	ate signed (Month,	Day, Year)
					A CRNP		-) (Time -)		14919	14		1-(bruary 16	,2010
			Mana and addr	n Grat	completed cause of d	, Cha	d (Type, P	Tous	61,	MD	2120	4		
Re	Stategistra		31. Date filed (Mont	EB 1 7 20	6701 N	ar's Signature	-	. 4.1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Gallik	Sta 1- For State Registrar	te of Maryland / D	epartment of Certificate of		i Mentai H		eg. No. 201	0 03908		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,	Robert T.	Gallik			Date of Deat Month February 2	Day Year	3. Time of Death 0951 hrs		
	4a. Facility Name (if not institution, 405 Glenwood Road	give street and number)		b. City, Town, or L Glen Burnie	ocation of Death		4c. County of De			
Funeral Director	5. Social Security Number	7. Age (lr	n yrs, last birthday) 6 Yrs.	If Under 1 Year Months Days			h(MM/DD/YYYY) 9. 5/1963	Birthplace (State or reign CountrMaryland		
Aaryland 28s-f show any 1.at once. ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	c. City, Town or Locati					10d. Inside City Limits 1 Yes 2 X No		
the Maryland a or 28a-f sh rified at once	10e. Street and Number 405 Glenwood Ro		oren bui	10f. Zip Code 2106:	1	10	og. Citizen of What C			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 3 Midowed 4 V Divor	12. Was Decedent Eventried Armed Forces? 1 Yes 2 X ced If Yes, Give Year	No If Yo	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto		White, etc	nerican Indian, Black, White		
5-0036 ed within 72 hours aff tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	ry only highest grade comple College (1-4 or 5+)	during mo	's Usual Occupations of working life. It	DO NOT use reti		16b. Kind of Busines Auto Re			
215-0(be filed wintal Hygier rked other rent, the M Be Con		Andrew Art	hur Gallik	Sr.	8. Mother's Name Dor		Maiden Surname) se Green			
MD 21 d 2 should th and Mer a 27 is man umatic ev	19a. Informant's Name/Relationshi Andrew A. Gal		14 An	chor Stre	eet	Westmins		land 21157		
Limore, Pages I and ment of Heal tant: If iten or other tra	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spe	cify:	20b. Place of Disposi crematory or oth Cedar Hill	er place) 1 Cemeter	ry	k ^D) ^{ate}		e, Maryland		
	21. Signat of Fineral Service Li	ledridge	e 140	001 Ritch	ie Highv	way Balt		ryland 21225		
Physician /Medical Examiner	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	a. <u>Atheroscle</u>	rotic card				st, shock, of flear	Between Onset and Death		
ier	Sequentially list conditions,	b								
uted d ansit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) d.	ence of):							
50, te be executed ysician and burial - transit	X UNPENDED	AMENDED	27,permE,	g900 2.18	8.10 TT					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. In the thin the function of the thin certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Estimates		23c. If yes, outcome of Live birth Pregnant at time Unknown	2 Fet	al death 3 er (Specify)	Ectopic pregna	ency	23d. Date of deliv Month	ery Day Year		
ry, P.O. I rices that the signed by the detached by the detached by the detached by PF		ns contributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.			to the cause of death?		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. It Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P										
/ital /sician: nis certi director	25. Was case referred to medical examiner? 1 V Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient		of Death (Check of Dither 4 Nursin		Residence 6 🗸 Ott	ner: Scene		
ion of Vi tending Physi eath. tor: After this the funeral di	27 Mannes of Death		28b. Time of In		at Work?	28d. Describe h	ow injury occurred			
Division or spital or Attending hours after death. meral Director: After y filled in by the function: Certification:	3 Suicide 6 Could determ	not be 28e. Place of Injury	- At home, farm, stree	rm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Nu or Town, State)						
To the Hospital within 24 hours To the Funeral completely filled		sician: To the best of my kn iner:On the basis of examina and manner stated.	-							
To wit To cor	1 1 1	and marrier stated.	<u>.</u>	29c. License O.C.M			29d. Date signed (Month, Day, Year) February 3, 2010			
	30. Name and address of person w		(Item 23a) 111 Penn Stree	t, Baltimore, M	/ID 21201					
State Registrar	les les Les di 1997 V-307 IV	32. Registrar's S	signature	1						

	-	For State Registrar	State of M	laryland	•	artment tificate			and M	1ental Hy	/gien Reg. N	001	0 0200	
Physicia Medic	al	1. Decedent's Name (First, Middle, La Margaret Gilm	an							2. Date of De Month Februa	eath	14 20°	3. Time of Death 2:57 A N	
Examin	•		spice				rown, or On i ι	Location	of Death		4	c. County of D Baltin		
uneral irector		214-22-0017	7. Ag ☐ M 2 🂢 F	ge (In yrs. last 82	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth By, Yeg	9. Birthplace (State or Fo		
3a-f show iffied at	ector	Usual Residence of Decedent 10a. State Maryland Baltim	ore	10c. City, T	own or Loc	cation						10d. Inside City Lir 1 □ Yes 2 √		
ral", or items 23a or 28a-f show Examiner must be notified at	eral Dir	10e. Street and Number 4703 Mawani Road				10f. Zip Code 21206					_	S.A.	t Country?	
ural", or nem J Examiner m	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates.	Ever in U.S.		Vas Decede Yes, speci				cify Yes or No Rican, etc.)			American Indian, Vhite, etc. Vhite	
any injury or other traumatic event, the Medical Exal once.	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-10)				(Give kind of work done during most of working						I	Kind of Busin	,	
atic event	To Be	17. Father's Name (First, Middle, Last) Kennard Gerwig								e (First, Middle Virgini				
ner traum		19a. Informant's Name/Relationship (i										or Town, State 1and 21		
jury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	20b. Plac cem Gdns	of F	sition (Name natory or oth aith	cem.		2/19,		Ba1	timore	y or Town, State , Maryland	
any in		21. Signature of Funorel Service Licen	aéé		11	Name and	Addres	s of Facilit	yRuc⊦ Tov	k Towso wson, M	n Fi lary	uneral land 21	Home, Inc. 1204	
for use as the burial-transit and the second and th	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as	a consequence a consequence a consequence	ce of):								Cnset and Death	
	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown								23d. Date of delivery Month Day Yea				
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page 2 sho	Comple			···						24a. Was auto perfo 1 \square Yes	psy ormed?	prior deat	autopsy findings available to completion of cause of n? Yes 2 □ No	
irector,	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:		/O. 4 4 4		Othe	r: Dea				- W	HOCDTOR	
he funeral c	Certificate: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigatio	28a. Date of inju (Month, Da	ient 2 ER ury 28 y, Year)	b. Time of injury		c. Injury work	at	2	me 5 □ Resi 28d. Describe I			pecify) HOSPICE	
lled in by	al Cert	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)					- 1	City or Tov	vn, Stat	re)	Rural Route Number,	
or the rule and brector, when this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of iner: On the basis of e se Practioner: To the	examination an	d/or investi	gation, in m	y opinio	n, death oc	curred at	the time, date a	and plac	e, and due to t	he cause(s) and manner state	
<u>0</u> 00		29b. Signature and title of certifier	Mark	(fl	P		License	number	29		29d. Da		onth, Day, Year)	
		30. Name and address of person who JENNIFER HAUF, C 31. Date filed (Month, Day, Year)		leath (Item 23 DULANI			RD.	TIM	ONIUN	4, MD 2	109	3		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03908 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February2,2010 Gonglewski 10:30A M Jerome Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death 603 South Ann Street, Apt409 Baltimore City Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 D Days Hours Min OCTI6. Maryland Director 215-30-9319 74 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore City 14 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 603 South Ann Street, Apt 409 21231 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: 3 ₩Widowed 4 □ Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Owner Opérator Bar 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gonglewski Frances Nadolny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar tant; If item 27 is Madeline Heaps / Sister 1100 Krueger Avenue Rosedale, Maryland21237 permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Febftary 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17,2010 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facilit aczorowski Funeral home, P.A. 21. Signature of Funeral Service Licensee Y 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of lingury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 🗆 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural work?
1 Yes 2 No 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State Medical 29a Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 15,

State Registrar 31. Date filed (Month, Day, Year) FEB 17 2010

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Physician /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Funeral Baltimore, Maryland 21215-0036 þ Completed is marked other Be 2 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. **Physician** /Medical Examiner

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as attending I for use as

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e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the

24 hours a

To the within 2

Division of Vital Records, P.O. Box 68760,

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Elizabeth 9:00 PM Josephine Haviland February 13, 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Heritage Nursing Home Baltimore Dundalk Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Davs 1 □ M 2 🛛 F Months Hours Min 218-44-4628 3/28/1917 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 7834 Denton Avenue Α. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lewis Mary Louisa Germeroth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Gernhart (Daughter) Sparrows Point, Maryland 21219 7834 Denton Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus: Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Fssex, Maryland 21221 23a. Part 1. Enter the disease, or confication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. THEROSCLEROTIC CARDIOVAS WICAR Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): DERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine DEMENTA Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **1** No 1 □ Yes 2 **1** No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number el-Place Dundalk MD 21222 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day & Year Debrucky & 2010 Dav 12:50 FM RYSTAI 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Year 1992 18, 17 Nov Maryland 216-37-7861 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 No Baltimore City 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 2484 Shirley Avenue 21215 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student High School 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wister Hardy Josphine Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wister Hardy 1080 Mt. Olivet Road, NE, Washington DC 20020 (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/18/2010 Donation 5 Other (Specify) St. Stanislaus Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Weatherford Funeral Service 2431 East Oliver St, Baltimore MD 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line netasta ANCER Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

items 23a or 28a-f show er must be notified at

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Department of H Important: If ite any Injury or ot once.

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

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MD

physician and s the burial-transit signed by the at ate has ieral Director: Af

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		Due to (or as a consequence or).										
Examiner	Sequentially list conditions, it any leading terms and cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence of):										
edical Exar	that initiated events resulting in death) Last	C										
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year									
ò	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1									
Completed			24a. Was an autopsy autopsy performed? 1 Yes 2 \subseteq No 1 \subseteq 4b. Were autopsy findings available prior to completion of cause of death? 1 \subseteq Yes 2 \subseteq No									
9	25. Was case referred to medical	26. Place of Death	Check onl. one									
ě	examiner? 1 ☐ Yes 2 No	Hospitals 3 4	me 5 Residence 6 Other (Specify)									
ation:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Unjury 28c. Injury at Work?	28d. Describe how injury occurred									
Certification:	3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
dical C	29a. Certifier (check only one) Certifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause(s) and manner as stated. Ted at the time, date and place, and due to the cause(s)									

State Registrar

MI Calvin 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

ES-000

29d. Date signed (Month, Day, Year)

February10

600 North Wolfe St, Baltimore, MD, 21287

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a

To the Funeral C

completely filled

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 14 HARGRAVE Physician/ 1:25A M ELSIF ebniari 2010 Medical Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death Chapel Hill Nursing Kandallstown Baltimore ttome 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD 1 □ M 2 X F Months Days Hours Min 217.14.912 Yrs. Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore **UWINAS** Mills 1 Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 101 Village Mill Court #9 Funeral USA 2117 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examins once. Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: Plack. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) LAR Cleaning Manager 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည bsech Butter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Village Mill Court #9 Owings Mills MD 21117 Gloria E. Smith Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03 01/10 Biamson Owings Wills, MD Forest 21. Signature of Funeral Service License 22. Name and Address of Facility Vaugan C Greek Funera Services Janos Road Pandallstown ND 21132 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final newethneon Physician ulm disease or condition resulting in death) ma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner franciscon growth and cause. Enter Underlying Cause (Disease or iinjury Due to for as a pune country of Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the <u>und</u>erlying cause <u>give</u>n in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Illes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed / 2 No page 1 Yes 2 No ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 200 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 🛣 No 5 Pending after death. 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and Nitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/15/2010 125112 Ceto Owings Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Sucte 101 20, crossroads 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** February 2010 12, 4:55 Α Ada Mae Hutchinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil County Sunny Acres Assisted Living North Fast
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. 1 □ M 2 🛛 F Davs Hours 89 **Director** June 5, 1920 Baltimore MD. 212-07-3506 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Exminimations to modified at 1 ☐ Yes 2X No Director Maryland Cecil County North East 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21901 33 Dr.Carr Road United States Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔣 No Specify White þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 09 N/A Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Harry Phillips, Sr. Lillian Meyers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert D. Hutchinson, Sr. (son) 230 Chantrey Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other p Evans Funeral Chapel Rel Air Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any injury or o Feb. 16, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Forest Hill, Maryland (Jeffrey L. Cair, Sr.) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road, Timonium, Maryland 21093 21. Signature of Funeral Service Lice 23a. Party. Enter the gispase, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AI **Physician** HTN /Medical Due to (or as a consequence of) **Examiner** Demontia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed GERD Due to (or as a consequence of). P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) as & feet Leving ٩ 1 ☐ Yes 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Attending Phy hours after death. neral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 14 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Madhu Sachder M.D.

31. Date filed (Month; Day, Year) -

E. Cecil Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

ORIGINAL

0026183

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1934 PM 20 9 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Macyland MD N/A timor Carca Social Security Number 219 26 3197 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours 70 Marvland Director 08/01/1939 Usual Residence of Decedent or 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland items 23a or 28a-f sho her must be notified at Director Maryland N/A Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1401 Elmtree Street U.S.A. 21226 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ō þ 1 Never Married 2 Married ☐ Yes 2 🗓 No Maryland 21215-0036 1 🗆 Yes 2 🏝 No Yes, Give Specify "natural" 3 Widowed 4 Divorced Specify: Completed White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9th Maintenance Worker Kennecott Refinery Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ William R. Hartman Bessie Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kathy Hartman / Wife 1401 Elmtree Street Baltimore, Maryland 21226 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 02/15/2010 Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, of complications that caused the death. Do not enter shock, or heart failure. Lief only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 🕅 No ပ္ MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After (Month, Day, Year) X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation by the f 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direct

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Cartifying Nurse Practioner: To the best of My knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Christina Barbara Hurley FEBRUARY 2010 Medical County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BALTIMORE JOHNS HEAKINS BAYVIEW MEDICAL CENTER . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 921 218-07-3005 1 M 2 KKF 88 Months Days Hours March 29 Director Mary Tand Usual Residence of Decedent 10b. County N/A ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location Baltimore 10a. State 10d. Inside City Limits with the Maryland Director Maryland Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4931 Sinclair Lane 21206 LISA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Andrew Stewart Magdelina Schmitt 19a. Informant's Name/Relationship (Type, Print) William C. Hurley/ Husband 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4931 Sinclair Lane Baltimore Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 2/19/10 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck linc 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Enysician/ MYOCARDIAL INFARKTION disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** FRACTURE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of 2 DAYS Exam burial-transi FALL CERTIFICATION APPROVED BY MEDICAL EXAMINE and that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? this certificate 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; to the funeral director; the funeral director; the funeral director; the funeral director; the function of the function of the funeral director; the function of the function of the function of the funeral director; the function of t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: 1 Anpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 🗌 Natural 5 Pending 0200 AM 2 Accident FELL DOWN STAIRS Investigation FEBRUALY 13, 2010 Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4931 SWYAIR LANE BALTMERS MD Home Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 0005 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE, MA BRADFORD DAVID UINTENS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

FEB 172010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P3 2010 04:05am Margaret Ε. Higdon Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Ellicott City 3445 Nanmark Court If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Days 1 M 2 X 63778/1914 219-28-9888 95 MD Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Ellicott City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3445 Nanmark Court 21042 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. 3 X Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate 12 Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sindall Mildred Beckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 3445 Nanmark Court, Ellicott City, MD 21042 Richard Higdon, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 02/19/2010 4 Donation 5 Other (Specify) Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J.Ruck, Inc. Mandra Eslai 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 outcome of pregnancy 23b. Was decedent pregnar 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed should peen 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to me al 26. Place of Death (Check only one) Be examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 1 7 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** C. Howland February 13. 2010 /Medical 9:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Retirement Community
Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) Baltimore 9. Birthplace (State or Foreign Catonsville 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1□M 2XF Hours Director 288-38-7431 94 Feb. 12, 1916 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts r 28a-f show notified at 1 ☐ Yes 2 No Director Baltimore Maryland Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 509 Maiden Choice Lane RG 105 S

11. Marital Status

1 □ Never Married 2 □ Married

3 ▼ Widowed 4 □ Divorced

1 □ Ves Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medit al Examiner must. 21228 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify. Specify: þ White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Poole Cheadle Elizabeth 2 Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1685 Belhaven Woods Court Pasadena, Maryland 21122 Harris C. Howland, Sr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State St. Margaret's Cem 02/18/10 4 Donation 5 Dother (Specify) Annapolis, Maryland 21. Signature of Fun Service Licensee McCully-Polyniak Funeral Home, P.A. <u>3204 Mountain Road Pasadena, Maryland 21122</u> 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dysolana /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 Ø No Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed' 20 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled it by the funeral 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Division 11 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Light Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

am

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

POURO40

Type, Print) Choice Lan, Calonsorth

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 37am Manus Medical 4a. Facility Name (if not institution, give street and number)

Joseph Ritchie House or Location of Death Baltimore 4b. City, Tow 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec. 10, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Cuba Year) 1917 1 □ M 2 🖾 F 92 Months 213-54-3500 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 21228 Chantilla Road 2136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White Cuban Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 18. Mother's Name (First, Middle, Maiden Surname)
Aurelia Ramos 17. Father's Name (First, Middle, Last) မ Rogelio Hererra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2136 Chantilla Rd. Baltimore, MD 21228 Roger M. Hernandez / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20c. Location - City or Town, State Date 1 Burial 2 Kremation 3 Removal from State 2/13/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed Orota Marshal Name and Address of Facility Maryland Cremation Services Klien PO Box 1413, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque te of): **Examiner** Sequentially list conditions, if any and grown cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a nunsequencia of: ttending physician and or use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rds, 2 2 40 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy the funeral director, page 1 ☐ Yes 2 ☐ No 1 🗌 Yes Physician: Be 25. Was case referred to medical Vital 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) tasoire After this 27. Manner of Death o 28a. Date of injury (Month, Day, Year) 28b. Time of • Hospital or Attending Pl 124 hours after death. • Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after de To the Funeral Directo Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 evsus - Bucco 31. Date filed (Month, Day, State Registrar

uea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per G900 2/25/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. POMPE 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY Frederick Donald Haskins Medical 4c. County of Death give street and number) Facility Name (if not institution, 4b. City. Town or Location of Death **Examiner** HEALTH CARE SYSTEM PERRY MIDA VA MARYLAND FREDERIER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Y 15, 1933 219-26-2065 76 Director May D.C. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Baltimore MD Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 21220 USA NASKINS 6811 Cornell Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

Army 1 \(\times \) Yes 2 \(\times \) No \(\times \) Army If Yes, Give \(1951-1954 \) Year or Dates. Black, White, etc. ò 1 Never Married 2 M Married NAME KNOW TO PHYSICIAM - HID Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the A ginee. Railroad Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia McCeivey Frederick Graham Haskins 19a. Informant's Name/Relationship (Type, Print)
Erika
Eriks Haskins / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6811 Cornell Road, Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 🖾 Cremation 3 D Removal from State 12/16/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service Licensee Dorota Marshall arroll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between THE RIND BUTH Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LMONARY MBOL15M Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown cate has been siç ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No ... unv. mosputation externating ripsticiatif. The white A bours after death.

To the Funeral Director, After this certificate by completed filled in by the funeral director, page. 2 🗌 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 2 🗘 No ျှ 1 A Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number f person who completed cause of death (Item 23a) (Type, Print)

SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

10-01032 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kathleen Herfel 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1640 hrs Kathleen Herfel Medical Examiner February 4, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 414 Folcroft Street Baltimore If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min 216-88-5611 47 Months Days Hours Sep.29, 1962 Director Country) MD 1 M 2**x** F Usual Residence of Decedent 10d. Inside City Limits any 10b. County 10c. City, Town or Location Baltimore MD 1 X Yes 2 No hours after death with the Maryland Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 USA 414 Folcroft Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes Specify: White If Yes, Give Year Yes 2 No specify. 4 Divorced δ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 F Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 12 Homemaker Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline unknown æ Hugh Brown 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 414 Folcroft Street, Baltimore, MD 21224 Roger Hornberger Jr. / Fiance 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 2/11/2010 Woodbine, MD 4 Donation 5 Other Specify 22 Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licens Marshall 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Methadone and clonazepam intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 23a,27, 28a-f,perm,E g901 3/29/10 TT X UNPENDED physician the burial -Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year attending or use as the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24a. Was an 24b Were autopsy findings available prior to completion of cause of autopsy performed' 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical æ Other₄ examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 this 1 🗸 Yes No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death Certification: Natural 1 Yes 2 No 5 Pending within 24 hours after death To the Funeral Director: ector: by the f Fd 2/4/10 Fd 4:20 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 414 Folcroft St altimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide found at residence determined 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 5, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD gistrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 🛴 Decedent's Name (First, Middle, Last) 2 Date of Death Februar 9 9,2010 Physician/ 2:40A. M Margaret Elizabeth Hamrick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Days Hours 215-18-3609 86 June 34, 1923 Maryland Director Yrs Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1x Yes 2 No Md. Baltimore City ō 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 6703 Graceland Avenue 21224 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 21 No Black. White, etc. "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Seamstress Clothing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Haberkam Lloyd Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 9542 Patricia Mongelli/Niece Bauer Avenue Nottingham, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

NY iew Crematory 1 Burial 2 Cremation 3 Removal from State Bayview Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2.2010 21. Signature of Funeral Service Lice 22. Name and Address of Facilitaczorowski Funeral Home, P.A Dundalk Avenue Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ a. END STAGE DEMENTIA disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 X No g | IInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: <u>-</u> 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending 1 Yes 2 No М Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined

MARGARET HAMRICK Records, Division of Vital 24 hours

a.m.

2:40

2010

6

FEBRUARY

State Registrar

Medical

29a. Certifier

only one 29b. Signature and t

JACKIE JONES,

DHMH 17 Rev 7/2009

within 2 To the F

2300 DULANEY VALLEY RD.

berson who completed cause of death (Item 23a) (Type, Print)

CRNP

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26 per MD g900 2/17/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** IMBIEROWICZ OAMMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 610 H. Moores Mill Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 220-20-3864 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Min. Months Days 1 ☐ M 2 🖫 F Hours Apr 30, 1927 Director 82 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.

To 7 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "natical Experience must be retified at 177 Yes 2 □ No Director Md. Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. 644 South Lakewood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes Z□No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) St. Joseph College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angeline Karczewski Joseph Imbierowicz permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m.
any injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Imbierowicz/Brother 644 South Lakewood Avenue Baltimore, MD21224 20a. Method of Disposition

T Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) February 19, 2010Baltimore, Maryland St.Stanislaus Cemi 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FaciliKaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) CENTERCATION APPROVED BY MEDICAL EXAMINER iis certificale has been signed by the attending physician and director, ptge 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 - Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificale 2 🗆 No 1 □Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Niece's Home Hospital: Other: 4 Nursing Home 1 Mes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ← 6 K Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural November 2009 tall from standing 1 Tyes 2 Accident 3 Suicide unknown 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide alrewood Stieet Baltimore)treet 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Patient Known as: William Sordan

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

_	1 - State Registrar					ndelible Ink 2010 artment of lartificate of		1	-	Reg. No	00	10	03	392
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Funeral Director	10e. Street and Nur	mber				10f. Zip Code				10g. Cit	tizen of W	hat Cour	ntry?	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year one Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Future Care Irvington 5. Social Security Number Birthplace (State or Foreign Country) NC. 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Hours (Month Day, Year) 05-04-29 1 - M 2X-XF 213-28**-**1144 80 Director Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21217 2004 Presbury Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African δ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry

John H. Murphy (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th Grade College (1-4 or 5+) School #119 Teacher Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jones Esther Harry Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3303 Round Circle Baltimore, MD 21225 19a. Informant's Name/Relationship (Type, Print) 3303 Round Circle Baltimore, Linda Jones-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Date emetery crematory or other p. Zion Cem 1 X Burial 2 Cremation 3 Removal from State 02-18-10 Lansdowne, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. MD 21217 Street Baltimore, 638 Ν. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): signed by the attending physician at be detached for use as the burial. Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy perform 2 LN 1 Yes Yes completed filled in by the funeral director, Be 25. Was case referred medical 26. Place of Death (Check only one) examiner? 2 🗖 No Other: Certificate: To 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Natural injury 5 Pending 1 Tes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 21 N. Sucewst Belline MD 21201 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Radistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS, G901, 37372010, WS
State of Maryland / Department of Health and Mental Hygiene) For State Registrar 03924 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Eugene 2. Date of Death 3. Time of Death Jerry Sr. Day Year Month **Physician** 02 10 2010 11:22a. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months 79 Yrs 251-46-8192 Director 06 23 30 SC Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a, State 10b. County 10c. City. Town or Location or 28a-f show ital Hygiene. Id other than "naturel", or Itams 23a or 28a-f show event, the Mydicul Examinar must be redified at MD NA Baltimore 1 ☐ Yes 2X No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 U.S.A. 4018 Dorchester Road Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 2 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sparrows Point 6th grade Crane Operator ages 1 and 2 should be filed went of Health and Mental Hygier at: If Item 27 Is marked other thy or other traumetic event, Italy or other traumetic event, Italy na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Jerry Bertha Abrams Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4018 Dorchester Road, Baltimore, Md 21207 Cynthia Jerry-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or King Memorial Park 2/20/10 Woodlawn, Md * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md Tarch amali 23a. Part1. Enter the disease, or completeions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Cancer disease or condition resulting in death) 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PV Division of Vital Records, pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide after within 24 hours a To the Funeral [To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptiler D00693 02,12,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Wath am Woods A, Parliville Mittal Prajapat MP 21234 8813 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND ITEM#5perfH, G901, 3/10/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Kenneth A. Johnson 2010 6:30 /Medical February_ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Glen Burnie 1102 Wynbrook Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 84 219-10-7583 Director Maryland 02/06/1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director Glen Burnie Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1102 Wynbrook Road 21060 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 ★Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ģ Specify. 3 Widowed 4 Divorced Year or Dates: White "natural". Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, Ine Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Coast Guard Yard 10th t of Health and Mental Hy titem 27 is mortal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Johnson Emma L. Seamont ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7876 Americana Circle #204 Glen Burnie, MD. 21060 Judith Sneeringer / Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 02/05/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) P.A. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** terioselevotic disease or condition resulting in death) 5045 C /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical attending 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 29a. Certifier 1 __certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) merica Ct. 2103 mD

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

10-01064 Young Joung Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oung Joung		State of Maryland / Departmen 1- For State Certificate Registrar			and	Menta	al Hy		Reg. No.	20	10	0392	(
Physicia ledical Examin		Young Chul Joung					2	2. Date of De Month February	Day	Year 10		3. Time of Death 2212 hrs	
		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4	b. City, Tov Bel Air	vn, or Lo	ocation of	Death		40	c. County of Harford	Death		_
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 137-02-1334 1 M 2 F 55	y) Yrs.	If Under	1 Year Days	If Under	24Hrs. Min.	8. Date of B	,	1	Cou	iplace (State or Foreigntry) uth Korea	jn
'any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	_ocati	on								10d. Inside City Limits	,
aryland 8a-f show at once,	Director	Maryland Harford Abingdo	on	10f. Zip Co	ode				10g. Cit	izen of Wha	t Count	1 Yes 2 No)
ith the M 123a or 2 notified		106 Love Grove Ct. 11. Marital Status 12. Was Decedent Ever in U.S. 113	N/o	210		onio Origin	2/500	cify Yes or N		ith Ko		an Indian, Black,	
	/ Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Ye	es, specify (Cuban, I	Mexican, F			0-	White,	etc.		
72 hours at "natural	leted by		edeni	's Usual Oc ost of workin	cupatio	n (Give kir			16b.	Kind of Busi			
MD 21215-0036 d 2 should be filed within 72 hou th and Mental Hygiene, n 27 is marked other than "nat numatic event, the Medical Exa	Completed	17. Father's Name (First, Middle, Last)	ini	ster	18	3.Mother's	Name (I	First, Middle,	Maiden	Relig Surname)	ion		_
	o Be	Ki Sik Joung	· P					n Kang	57 - KL	- 652 -			
and 2 should lealth and Me tem 27 is ma traumatic co	ř	A. C.						ral Route Nu Dingdo	,	•		Zip Code)	
Baltimore, MD 2' permit. Pages I and 2 should Department of Health and M Important: If item 27 is mr injury or other traumatice.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of D crematory	isposi or oth	tion (Name er place)	of ceme	etery,		Date	20c.	Location - C	ity or T		_
altim mit. Pa partmer portani	1	4 Donation 5 Other Specify: Bel Air 21. Signature of Funeral Service Licensee	<u>M</u> ∈ 22. N	Moria	1 Go	dns.	2-:	13-10 ne, P.] Be	el Air	, M	aryland	_
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not er	13	1/ CO	kesi	oury	Ra.	<u>, Abın</u>	qdor	n, MD	210	09 Approximate Interva	
Physician /Medical caminer	Ì	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			rymig, sc	dori do care	urac or r	espiratory ar	1631, 311	ock, or riear		Between Onset and Death	
	ě	Sequentially list conditions, if any, leading to immediate b	_								-		
ecuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.		-	-				-				_
60, ite be execut hysician and burial - trai	Medical	UNPENDED AMENDED											_
Box 68760, death certificate be executed the attending physician and for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	=	al death er (Specify		Ectopic p	regnand	су	23	d. Date of de Month	elivery Da	ay Year	
P.C	ھ	Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying ca	iuse giv	en in Part	I.		_	_		ne cause of death?	
of Vital Records, P.C. og Physician: The law requires that ther this certificate has been signed ineral director, page 2 should be deter	Completed							24a. Was		pri		ppsy findings available mpletion of cause of	3
Vital Rec sysician: The this certificate	ဒ္ဓ	25. Was case referred to medical		26.	Place o	f Death (C	heck on		2 V N	lo 1	Yes	2 No	_
Vita	Lo Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa	itient			thor:		Home 5	Reside	ence 6	Other:		
- # ~ # l	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	e of In			at Work? s 2 N		8d. Describe	how inj	ury occurred		<u>-</u>	
Division of V To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After it	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, (Specify)	stree	t, factory, of	fice buil	lding, etc.	2	8f. Location or Town,		and Number	or Rura	al Route Number, City	
Fo the Hosp within 24 ho Fo the Fund completely f	Medical	29á. Certifier 1 Certifying Physician: To the best of my knowledge, death one 2 Medical Examiner: On the basis of examination and/or inversand manner stated.											
	ž	296. Signature and title of certifier			icense r					Date signed oruary 9, 2		h, Day, Year)	
5.1	1	Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 P	enn	Street, B	altim	ore MD	2120	1					_
ノ V Sta	te	31. Date filed (Month Day, Year) 2010 32 Registrar's Signatur	A	Street, B	aumi	JIE, IVID	Z 1ZU						_

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 200 **Physician** Jones Kory B. /Medical 4b. City. Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIKIOK B. Date of Birth (Month, Day, Year) Dec. 24, 1990 ocial Security Number 7. Age (În.vrs. last birthday) If Under 1 Year If Unde Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 215-31-0732 19 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the We stone Examiner must be a different Baltimore MD Essex 1 TYes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21221 300 Greyhound Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes· 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ... within ... wental Hygiene. r 27 is marked other than "r r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) School Student 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Mary Ann Duggan Leroy E. Jones Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /cousin 106 Susan Place Dover Delaware Susan D. Krs Department of Health Important: If item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Baltimore MD Bayview Crematory 2/4/10 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? Be (director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 124 hours after death.

Be Funeral Director: A pletely filled in by the funeral place. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Procedifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only

Division of Vital Records. the ျှ

P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certif



mpleted cause of death (Item 23a) (Type, Prin

and manner stated

dueDacoAve Batture as

29d. Date signed (Month, Day, Year)

within 2

10-01078 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Darlene Jones State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1232 hrs Medical Examiner Darkene February 6, 2010 R. Sones 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1109 East Chase Street Baltimore If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year Funeral Days Hours oreign Country) MARY Land Director 218-44-4928 2-27-1947 1 M 2 F 62 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ij 10a. State 10b. County 1 Yes 2 No tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Mel Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? USA Street Chase 21202 109 E 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes Specify: BLack 4 Divorced 1 Yes 2 No specify: 3 Widowed If Yes. Give Year \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 97 (ashier of Health and Mental Hygiene.

If item 27 is marked other th 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) SAMES Sackson Ida Be NORRIS 1) , 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Street Chase verett 110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) 1 Burial 2 Cremation 3 19/2010 Noodlann Cometers portant: 4 Denation 5 Other Specify 22. Name and Address of Facility Miller 3 Metro polition chapel Broad way Balto. Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✔ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes mellitus Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Yes 2 V No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury 1 V Natural Pending 1 Yes 2 No hours after death. To the Funeral Director: the 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 16, 2010 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year, 32. Registrar's Signature State arked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Emma Katherine Koenig /Medical 02/05/2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital <u>Prince Frederick</u> Calvert 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, If Unde Hours **Funeral** Days 1 ☐ M 2 🖳 F Director 158-09-5859 Yrs 08/23/1919 90 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wedical Examinating is used by notified at **Funeral Director** Essex NJNewark 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 07102 160 Market Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications <u>Telephone Company Employee</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ို Charles Haller <u>Louella Wbhaus</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Koenig/Son <u> 2925 Hallowing Point Road, Barstow, MD 20610</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If ite any Injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 02/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility Ardent Cremation Services 21. Signature Funeral Service Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician erebrovascular Accident /Medical Due to (or as a consequence of): Examiner Carelio Voscular disease Scienchic there Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical þ Medical Certification: To Be Completed

Division of Vital Records, P.O. Box 68760. after death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	al death 3 🗆 Ectopi		23d. Date of delivery Month Day Year									
Part II. Other significant conditions	contributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?								
Atsi'al fi	brillation			1 ☐ Yes 2	□ No 3□ Probably 4閏 Unknown								
1				24a. Was an autopsy performed? 1 □Yes 2 ☑ 1									
25. Was case referred to medical examiner?		26. Place of Death (Check only one)											
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 ☐ Other (Specify)								
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28a. Date of Injury (Month, Day, Year) 28b. Time of Sorting of Unitary 28c. Injury at Work? M 1 Yes 2 No											
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ome, farm, street, fact fy)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and place ion, in my opinion, death occu	e, and due to the cause(urred at the time, date ar	s) and manner as stated. Indicate place, and due to the cause(s)								
29b. Signature and title of certifier			29c. License number	29d. D	29d. Date signed (Month, Day, Year)								
1 Cy	icm.c. Su	-ana	D 5065		7-8-2010								
30. Name and address of person who		, , , , ,	GYAN -C.	SURA	VA								
5851 2	leave chu	nonton	Road	Deale V	ND 20751								
31. Date filed (Month, Day, Year) FEB 17	32. Rysistrar's Signa	A. far	W	,									

10:00 A

10d. Inside City Limits

1 √ Yes 2 □ No

N.T

White

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year 10:10 PM Theodore 15, 2010 Stephen Kobal February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1555 Williams Avenue <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days 1**X** M 2 □ F Months <u> 218–36–3716</u> 68 April 5, 1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1555 Williams Avenue 21221 A. U. S. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married 1 □Yes 🎾 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Quality Control Road Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stinach Charles Kobal Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Darleen Kobal (Wife) <u>1555 Williams Avenue</u> Maryland 21221 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2618 Holly Hill Mem. Gard. Baltimore, Maryland Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Mary and 21221 23a. Earl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancer Una Due to (or as a connex ence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

\$

Completed

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ir than "natural", or items 23a or 28a-f sho

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite

traumatic

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

Exami Physician/Medical Completed Be Certification: To

sician and burial-tran attending physician for use as the burial ate has been signed by the page 2 should be detached this certificate

The law requires that the death certificate be executed the Hospital or Attending Physician: nours after death.

neral Director: After this
filled in by the funeral d within 24 hours a To the Funeral L completely

State

30. Name

5 ☐ Pending investigation

6 ☐ Could not be

determined

27. Manner of Death

1X Natural

2 Accident 3 🗌 Suicide

4 - Homicide

(Check only one)

29a. Certifie

29b. Signature

Medical

of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury

and manner stated

(Month, Day, Year)

29c. License number H-0063476

1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

4924 Boulevard Suite 200 Baltimore, MD 21236 Madder Campbell 31. Date filed (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 8901 3-15-10 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 2:16 P Kuiken February 9,2010 Hein /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. FutureCare Northpoint Eastpoint If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1☑M 2□F Months Director 217-40-1807 83 June 13,1926 Holland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, it e Modical Examiner must be notified at 1 Yes 2 No Director Baltimore Baltimore Co. MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States/Holland 7107 Fait Avenue Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Counter Sales 12 Years Stockman 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked out Be Anna Postomus ဂ္ Rinder Kuiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7873 Charlesmont Road Dundalk, Maryland 21222 William Kuiken (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. = 5 $2/\frac{15}{15}/2010$ Baltimore, Maryland '4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hythmias Pnysician 2 hrs /Medical **Examiner** Ochero tohoro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician as the t IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 12 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Had 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTERN 10 ASB BM

DHMH 17 Rev 1/2001

State Registrar MALIKA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Vear Month **Physician** 4:12 PM Margaret Frances Kohlerman February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Funeral 1 ☐ M 25 F Director 90 Jan. 21, 1920 Pennsylvania 233-28-9123 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinant be notified at 1 ☐Yes 2 XNo Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 325 Althea Court 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🛮 No þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Aircraft Manufacturer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Innent of Health and Mental Durwood Belmont Blake Rhoda Sharpe Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar R. Kay McCray / Daughter <u>325 Althea Court, Bel Air, MD 21015</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 □ Donation 5 □ Other (Specify) Richwood Cemetery 2-28-10 Richwood, WV of Funeral Service Licensee 22 Name and Address of Facility
McComas Funeral Home, P.A. 1 Min 1317 Cokesbury Rd., Abingdon, MD 23a. Part 1. Enter the disease, or complete the that caused the shock, or heart failure. List only the cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) CENTRE LETTON APPROVED BY MEDICAL attending physician for use as the buria the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical SEMINAL APPROVED BY MEDICAL EXAMINER IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) the a∏Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural fell-unwitnessed 1 ☐ Yes 2 MNo V10:00 am 29/10 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Fell athome 325 Althea G. Bel Air, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) lannan.

') V

DHMH 17 Rev 1/2001

Registrar

m.D. 500 Upper Chesapeake Dr. Bel Air, mp 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sonia Mannan
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2010 Year WANDA ILONA KISLY 1:30 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM HARFORD . Social Security Number 8. Date of Birth (Month, Day,) OCt. 23, 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F ^{Year} 19<u>21</u> New Jersey Director 137-16-9464 88 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show "aumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎽 No Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2701 Wheaton Ct. 21028 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Vending Machine life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manufacturer Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Romuald (unk) Balicki Elizabeth Helen Kowalczyk permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Kathleen K. Gentry / Daughter P.O. Box 336, Churchville, MD 21028 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Highview Memorial Gdr 2-15-10 Fallston, Maryland ²² Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, . Signatur P.A. Abingdon, 21009 Marvland 23a. Part 1. Enter the deease, or complications that caused the death, shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ RECTAL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death page 2 should be detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hospital or Attending Physician: The Jaw requires 2 No Records, Completed 1 🗌 Yes 3 Probably 4 Unknown been KISLY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 X No the funeral director. 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 2 X No ျာ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 X Natural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and otle of 29d. Date signed [Month, Day, Year] 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

DHMH 17 Rev 7/2009

Registrar

FEBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:25 P.M Eleonore February Gertrud Kavser Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Jan. 20. 19391 M 2 XF Months Hours Min. Mary I and Director 212-38-2618 71 Usual Residence of Decedent fshow 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itiem 27: is marked out than "natural", or items 23a or 28a-f sho any injury or or her traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2🏋 No Maryland Baltimore Stoneleigh 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 606 Regester Avenue 21212 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Research 5+ years Chemist Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henry Herman Kayser Julia Loehe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry H. Kayser (brother) 613 Regester Ave. Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Memorial Grins. 2-19-10 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Road Baltimore, Maryl Inc.₂₁₂₁₂ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death signed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate leted filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify) 1 Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 CRNP Frbruary 12,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Grat St. MD 21204 6701 N. Challs Towson, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 17 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year James Edward Lynch Sr. 6:00 PM Ph 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore mfig R If Under 24 Hrs Hours Min. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 09 28 Year) 1 X M 2 - F Country) 76 227-38-2594 **Director** NC Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore MD 1 🔀 Yes 2 🗌 No NA 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral or items 23a 2520 Quantico Ave 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hyglen important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exai any injury or other traumatic event, the Medical Exai Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Baltimore County (Give kind of work done during most of working life. DO NOT use retired) ynch, James Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Truck Driver Public Schools na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Tidwell Walter Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lizzie Lynch-Wife 2520 Quantico Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn 2/22/10 Woodlawn, 4 Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sign ture of Funeral Service Licensee Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardiac arrythemias 30 ininues Medical resulting in death) Due to (or as a consequence of): Examiner disease heart Lrear the rosclambic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or se's consequence of): Exam Demention 2 428 Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 in the past 12 months? Month Pregnant at time of death Day Year Other (specify) Unknown g 🗌 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown within 24 bours after death.

To the Funeral Director: After this certificate has been si

To the Funeral Director: After this page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 👱 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30494 -16-4c10 K NESHIMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) maidon choice lone Baltimore MA 81518 DESALMO 31. Date filed (Month, Day, Year) State FEB 1 7 2010 Registrar racke

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** 1timore Hospice 7. Age (In yrs. last birthday) If Unde 8. Date of Birth Birthplace (State or Foreign Country) If Unde **Funeral** (Month, Pay, Yea Months Min. Director ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Never Married 2 Married 3 Widowed 4 Divorced þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Informant's Name/Relationship (Type, (Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or To marc 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses M6155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ olon Lona disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, Immunode Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes Yes **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Man R149194 (RNP Library 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI N. Chales Gran 6701 Touson. MD 21204 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Month Feb. Physician/ 9:50 P M 12 Ruth Eva Lambert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Ste**ll**a Maris If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Maryland Min March 16,1912 1 □ M **XX**F 219-28-8603 97 Director Usual Residence of Decedent fshow 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State with the Maryland Director 1 Tes XX No Baltimore Towson MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral U.S.A. 21286 409 Virginia Ave. Apt.110 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: White 3XXVidowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carrie Martinek Julius Stark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 Walnut Ave. Owings Mills, MD 21117 Ruth Thompson / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot Dulaney Valley XX Burial 2 Cremation 3 Removal from State 2/15/10 Timonium, MD 4 ☐ Donation 5 Ø Øther (Specify) Memorial Gardens 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 21. Signature of ery Service 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a sonsequence of) Examiner 8/28/054 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown detached within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death Check only one) Be 25. Was case referred to medical examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) - Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an 2016 oleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Dav. Year) State

DHMH 17 Rev 7/2009

Registrar

10-01320 James Latham Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

mes Latham		State of Maryland / D	epartment (Certificate (itai Hygie	ene Reg	2010	03938
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)					ate of Death onth		3. Time of Death
edical Examin		James R. La 4a. Facility Name (if not institution, give street and number)	aciiaiii	4b. City, T	own, or Location		ebruary 13	3, 2010 4c. County of Deat	
		Harbor Hospital Center		Baltim	nore			N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 217 38 8072 1X M 2 F 67	yrs. last birthday) Y	If Unde Months				(MM/DD/YYYY) 9. Bit Foreit /1942	thplace (State or gn puntry) Maryland
, i	ļ	Usual Residence of Decedent 10a, State 10b, County 10c.	: City, Town or Loc	cation					10d. Inside City Limits
d how ar		Maryland Baltimore	Arbutus						1 Yes 2 No
Aarylar 28a-f s I at on	Director	10e. Street and Number		10f. Zip			100	g. Citizen of What Cou	
th the N 23a or notified		1304 Poplar Avenue	: !!0 [40.1		21227	-in2 / Cassifu	Vee or No	U.S.A	ican Indian, Black,
ath wit items	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	1 1		nt of Hispanic Ori y Cuban, Mexicar			White, etc.	ican indian, black,
after de		3 Widowed 4 Divorced If Yes, Give Year or Dates:	1		X No specify				hite
hours natur	Completed by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)			Occupation (Give king life. DO NOT		done	16b. Kind of Business	Industry
36 thin 72 than t	ple	10th	J	Janito	r		İ	Best Wes	stern Hotel
21215-0036 Suid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any ic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last) Patrick V.	Latham S	Sr	18.Mothe		st, Middle, Ma Hutton	aiden Surname)	
2121 ild be f Mental marke	o Be	19a. Informant's Name/Relationship (Type, Print)			(Street and Nu	,		er, City or Town, State	e, Zip Code)
MD 12 sho th and 127 is umati		Joan M. Latham / Wife		-	ar Avenu			, Maryland	
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is in injury or other traumatic		1 Rurial 2 Cremation 3 Removal from State	20b. Place of Disp crematory or	other place)		Da /1.0		20c. Location - City of	
timent rant:	ļ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Cedar Hi		-			Baltimore ral Service	
Bal perm Depa Impo injur	ı	Krome mameraent	1	4001 R	itchie H	Highway	Balt:	imore, Mar	yland 21225
Physician		23a- Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.			of dying, such as	cardiac or resp	piratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner	İ	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Car Due to (or as a conseque		Disease		_			Deau
		Sequentially list conditions, b							-
	ji.	if any, leading to immediate course Enter Underlying Gouse (Disease or injury that initiated	ince of):						.1
cuted ind transit	Examiner	events resulting in death) Last Due to (or as a conseque	ence of):						
e exe	edical	UNPENDED AMENDED							
68760, certificate be nding physic se as the bur	an/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of the limit of t		Fetal death	3 Fctop	ic pregnancy		23d. Date of deliver	y Day Year
Ox 6876(eath certificate attending phy for use as the b	siciar	past 12 months?	~	Other (Spec					
m o zol	Phy	Part II. Other significant conditions contributing to death but	t not resulting in th	ne underlying	cause given in P	art I.	23e. Did tob	acco use contribute to	the cause of death?
PO.	2			_			1 Yes	2 No 3 Pro	bably 4 Unknown
of Vital Records, ig Physician: The law requinuler this certificate has been shered director, page 2 should the	Completed						24a. Was ai	y prior to	utopsy findings available completion of cause of
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ital Rediction: The scentificate	Be	25. Was case referred to medical examiner? Hospital: 1 Innatient	2 🗸 ER/Outpatie		26.Place of Death	Nursing Ho		Residence 6 Othe	er
of V ing Phys	To To	1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month Day Year)			28c. Injury at Wor			ow injury occurred	
ttendir death. ctor: A	atio	Natural 5 Pending Accident Investigation			1 Yes 2			N	and Double Number City
Division tal or Attendia rs after death. al Director: A	Certification:	3 Suicide 6 Could not be determined (Specify)	- At home, farm, s	street, factory	, office building, e	etc. Zor.	or Town, Sta		ural Route Number, City
E 6 25		29a Certifier 1 Certifying Physician: To the best of my kn	nowledge, death oc	ccurred at the	e time, date and p	lace, and due	to the cause	(s) and manner as sta	ted
To the Howithin 24 F. To the Fu	ledical	one) 2 Medical Examiner: On the basis of examina and manner stated.	ation and/or investi		opinion, death o		time, date a	29d. Date signed (M	
	Σ	29b. Signature and title of certifier	1/400	250	O.C.M.E.			February 14, 20	
		30. Name and address of person who completed cause of death					1		
		Victor Weedn MD JD Assistant Medical Ex	A R	1 Penn St	reet, Baltimo	re, MD 212	201		
St	ate	31 Date filed (Month, Day Year) (1) Registrar's 5	signature (7)						

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Charlestown Nursing Home Catonsville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours Min 1 □ M 2 ☐ F Months Days 89 Yrs 214 12 0937 04/04/1920 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 U.S.A. 715 Maiden Choice Lane CC411 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. perrit. Pages 1 and 2 should be filed within 72 hours after to eperiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic more 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B G & E Secretary 12th 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Karl A. Lynch Anna Houdek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 5602 Ciffside Court Bernadette Sheppard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date (Knl. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demen **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown this certificate has been signed by al director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

Deneen

31. Date filed (Month, Day, Year)

711

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 8:57AM in senmere 0<98 2010 ted (440 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Arunde Anne Baltinose WAsing ton Redi Wester If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 216 32 5454 1 🗶 M 2 🗆 F Months Days Hours 05710/1936 Maryland 73 Director Usual Residence of Decedent בי יה ווומראפט otner than "natural", or items 23a or 28a-f show. traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🏝 No Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 904 Silver Maple Court 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. White Korean 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hertz Penske Trucking Refrigeration Mech. 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked ot any injury or other traumatic even ည George W. Linsenmeyer Sr. Ann Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Silver Maple Ct. Glen Burnie, Maryland 21060 Lisa Linsenmeyer / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State MD State Veteran Cem. 02/18/2010 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -0901 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Beetic Ulcer Disease, Chronic Lung Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Hospital or Attending Physician; The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No Director: After this certificate 2 X No Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospita Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours after of Funeral Direct determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner a stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a stated. within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c

State Registrar Drive

and address of person who completed cause of death (Item 23a) (Type, Print)

Roberto Gerardo Lonborcia

10-01075 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of I fillt ill black illacible ill	Ellouio / Ill copico / Illo Eogibio.
State of Maryland / Department of	Health and Mental Hygiene

UNF	(UNK		1- For State	State of Mary		artment o rtificate o		d Mental H	ygiene	2010	0394
	Physici	an/	Registrar 1. Decedent's Name (First, N	/liddle,Last)		runcate o	Deall		2. Date of Deat		3. Time of Death
Me	dical Exam		ROBERTO	GERARDO	LONGO	RIA			Month February 6	Day Year 5, 2010	1221 hrs
			4a. Facility Name (if not insti				4b. City, Town, or	Location of Death		4c. County of Deat	h
****	<i>'</i>		Johns Hopkins Bay		7. Age (In yrs.	last histhelass)	Baltimore	r If Under 24Hrs	IP. Data of Birt	N/A th(MM/DD/YYYY) 9. Bir	rthplace (State or
	Funeral Director		5. Social Security Number	6. Sex			Months Days			Forei	gn
			428-67-6958 Usual Residence of Deceder		4	9 Yrs	3.		SEPT.	6,1960 [∞]	MEXICO
	any		10a. State 10b. Cou		10c. City	, Town or Local	ion				10d. Inside City Limits
	Aaryland 28a-f show 1.at once,	'n	MD	N/A		BALTI	MORE				1 X Yes 2 No
į.	Manyla 28a-f	Director	10e. Street and Number				10f, Zip Code		10	ng. Citizen of What Cou	ntry?
0	th the Maryland 23a or 28a-f sho notified at once.		2926 E. PR				212			U.S.A	
	ath wi	Funeral	11. Marital Status 1 X Never Married 2		ecedent Ever in U Forces?		as Decedent of His es, specify Cuban			14. Race - Amer White, etc.	rican Indian, Black,
3	her de ", or i			1 Yes Divorced If Yes, Give Y		1.X	Yes 2 No	specify: ME	XICAN	Specify:	WHITE
	ours a atural	d by	15. Decedent's Education (Specify only highest gr	rade completed)		nt's Usual Occupati			16b. Kind of Business/	Industry
	6 n 72 h an "n ical E	olete	Elementary/Secondary (0-		(1-4 or 5+)	1	NESS PI		, cuj	EDITO	A III ON
	5-0036 lled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Mic	ddle Last)		B031		18.Mother's Name	(First Middle M		ATION
	b, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner.	Be C	FRANCISCO	LONGORIA	A				ENCIA	VALDEZ	
	212 ould b d Men d Men s marl	To E	19a. Informant's Name/Relat	ionship (Type, Print)			,	t and Number or F	Rural Route Num	ber, City or Town, State	
	MD d 2 sho lth and n 27 is		HORTENCIA L	ONGORIA/							
	S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1		20a. Method of Disposition 1 X Burial 2 Cremi	ation 3 Removal		crematory or ot	sition (Name of cen her place)	netery,	Date	20c. Location - City or	Town, State
	Limo Page Iment Tant:		4 Donation 5 Other	r Specify:	O.	K LAWI	V CEMET	ERY 2/2	0/10	BALTIMORE	E, MARYT AND
	Balti permit. Departm Importa	W.	21. Signature of Euneral Ser				LLY & Z	EILER :	INC. FU	JNERAL HO	ME
	Physician	6	23a, Part I, Enter the disease	e, or complications that	caused the death	n. Do not enter t	he mode of dying,	such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval
m	/Medical		failure, List only one ca Immediate Cause (Final dise		thermia	Complic	ating Le	ft Ventr	icular	Hypertrophy	Between Onset and Death
	Examiner		or condition resulting in deat		a consequence of						
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as	s a consequence of	of):					
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	cuted and transit	Exa	events resulting in death) La		s a consequence o	of).					l
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	tox 68760, reath certificate be ex attending physician for use as the burial.	Med	IF FEMALE:	23c. If yes	s, outcome of preg					23d. Date of deliver	<u></u> y
	6876(certificate nding physes as the b	ian/Me	23b. Was decedent pregnant past 12 months?	LIVE	e birth gnant at time of de		etal death 3	Ectopic pregna	ncy	Month I	Day Year
	Box e death c the atten ed for us	ysici	1 Yes 2 No 9	Unknown g Unk		eath 5 O	her (Specify)				
	O. E at the d by the etached	/ Phy	Part II. Other significant co	nditions contributing	to death but not r	resulting in the	underlying cause g	iven in Part I.		bacco use contribute to	
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	f Vit Physic er this ral dir	၉	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatient		y at Work?	3 · · · · · · ·	Residence 6 Othe	r:
	ion of tending Pheath	ion:	1 Natural 5	(Mor	nth, Day,Year)	1021 1		es 2 X No	subject	t exposed t	
	Division of Vital Records, tal or Attending Physician: The law requirers after death and Director. After this certificate has been siled in by the funeral director, page 2 should the continuous page 2 should the present the page of the funeral director, page 2 should the page of the funeral director, page 2 should the page of the funeral director, page 2 should the page of the funeral director, page 2 should the page of the funeral director.	ficat		investigation			et, factory, office b	uilding, etc.	2Bf. Location (S		ural Route Number, City
	Divis Hospital or A 24 hours after Funeral Dire	Certification:		determined (Specif	y) at so	cene			3300 Ea	stern Ave.	
	Division of Vital Records, P.O. Box 6876i To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the be		29a. Certifier (Check only one) Certifyin	g Physician: To the b	est of my knowled	ige, death occu	rred at the time, da	ite and place, and	due to the cause	e(s) and manner as stat and place, and due to th	ed.
	To the within To the comple	Medical	29b. Signature and title of ce	and manner	r stated.	and/or investiga	29c. License		t the time, date a	29d. Date signed (Mo	
		-	200. Signature and title of Ce	1 1 1	/1		O.C.M			February 8, 2010	
			30. Name and address of pe	rson who completed a	ause of death (Item	n 23a)	/				
			Zabiullah Ali, M.D.	Assistant Med			n Street, Balti	imore, MD 21	201		
		tate	31. Date filed (Month, Day, Ye	^{ear)} 2010 32	Pegistrar's Signat	ure					
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-01039 2010 03942 Edwin Ignatius Morrow State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month **Medical Examiner** 2105 hrs Edwin Ignatius Morrow February 4, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Main Street and Baltimore County Line Ellicott City Howard If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Director Country) 04/05/1968 216-82-3499 41 Yrs MD Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show "natural", or items 23a or 28a-f sho Examiner must be notified at once. MD Howard Director Ellicott 10g Citizen of What Country? 10e. Street and Numbe 21043 USA unk Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes within 72 hours after 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) rit. Pages 1 and 2 should be filed within 72 ho. ritment of Health and Mental Hygiene. Tanti: If item 27 is marked out or other trans. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Bernard Morrow

19a. Informant's Name/Relationship (Type, Print) <u>Fvevlyn Peach</u> ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Morrow/Brother 1207 N. Calvert Street, 2R, Baltimore, MD Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 02/17/2010 Hanover, MD Important: Ardent Cremation Services Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ardent Cremation Services Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval Physician 23a, Part I, Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line Madest Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of) icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? performed? ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Feb 4, 2010 Subject struck by train Natural 2044 hrs 5 Pending 1 Yes 2 ✓ No the Director: 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Main Street and Baltimore County Line , Ellicott City, MD determined (Specify) Train Tracks Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Funeral

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated.

Assistant Medical Examiner

egistrar's Signati

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

31. Date filed (Most

Pamela E. Southall, MD

29d. Date signed (Month, Day, Year)

February 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De State of Maryland / De	partment of Health and 17/2010dhb ertificate of Death	l Mental Hygi Re	ene g. No. 2 A I A	00010				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	2016	3. Time of Death				
20.00	Medic Examin	al	Terry Mitcham 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	January	16, 2010 Year 4c. County of Deat	10:45 a.M				
-/	~		943 Quantrill Way	Baltimore		lor soundy or sound					
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 \square F 7. Age (In yrs. last birthda 1 Yrs. Usual Residence of Decedent	Months Days Hours Mi		9. Birt	chplace (State or Foreign Letry) Carolina				
	/land f show ed at	tor	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits				
	e Mary r 28a- notifie	Director	MD Balti 10e. Street and Number	10f. Zip Code		og. Citizen of What Co	1 🛚 Yes 2 🗆 No				
	with the s 23a c	Funeral	943 Quantrill Way	21205	_	JSA	untry :				
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puet) Yes 2 X No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White					
15-(72 hou In "nat Medica	mple	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of w . DO NOT use retired)	rorking	l6b. Kind of Business I	Industry				
212	l within ygiene. her tha ht, the I		College (1-4 of 5+)	Contractor		Home Impre	ovement				
land	l be filec lental H rked ot tic even	To Be	17. Father's Name (First, Middle, Last) O.C. Mitcham		ame (First, Middle, Ma a Baumgari						
Maryland 21215-0036	and 2 shoulc Health and N tem 27 is ma other trauma			ailing Address (Street and Number or I			Code)				
Baltimore,	bage 1 an ent of He nt: If item		1 Burial 2 X Cremation 3 Removal from State cemetery, of	position (Name of rematory or other place) Cremation Svcs. 0		Poc. Location - City or					
Balti	permit. Bepartmental Importal any inju	j	21. Signature of Funeral Service Licensee Brent Bardsley per DVR	22. Name and Address of Facility 7522 Connelley D	Ardent Cre	mation Ser	rvice				
	Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Tinfection Due to (or as a consequence of): Severe Peripheral Vascular Disease Due to (or as a consequence of): Cause (Disease or injury that initiated events Countillated events								
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown Unknown Unknown Unknown Due to (or as a consequence of): d.	23d. Date of deli Month	ivery Day Year						
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ital	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpution 3 FR/Outpo	26. Place of Death (Cf							
Division of Vital Records,	I or Attending Physician: The la after death. Director: After this certificate ha i in by the funeral director, page	cate: To	27. Manner of Death 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 2 Accident Investigation	of 28c. Injury at	Home 5 Residen 28d. Describe how	nce 6 Other (Speci	ífy)				
Divisio	al or Attendi s after death I Director: A d in by the f	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,				
_	To the Hospital or within 24 hours after To the Funeral Dir completed filled in	Medical	29a. Certifier (Check (Check only one) 1	estigation, in my opinion, death occurre	d at the time, date and	place, and due to the c	cause(s) and manner stated.				
	To the within to the comp	-	29b. Signature and title of certifier Source m &	29c, License number D0060489	29	d. Date signed (Month)	, Day, Year)				
			30. Name and address of person who completed cause of death (Item 23a) (Type Karen Bowen, M.D., 9940 Franklin	Square Drive, Suit	•	,					
	Stat Registra		31. Date filed (Month, Day, Year) 2010 . Registrar's Signafure	all							

DHMH 17 Rev 1/2001

ORIGINAL

			Amend #30 per DVR g	ype or Print in B 900 2717/10 1 State of Maryland	ijack Indel il 7 Departme	ble Ink ent of H	k. Ensure A	All Copie Mental Hy	s Are Le	egible.	03945
	Physicia		State Registrar 1. Decedent's Name (First, Middle, Last)	Mapf	Certifica	te of E	eath	2. Date of De Month	Dav	Year W, ZOID	3. Time of Death
4.	Medic Examin		4a. Facility Name (if not institution, give structure) 5. Social Security Number 6. Sex	eet and number)	4b. Cit	ty, Town, or B der 1 Year	Location of Death Atimor If Under 24 Hrs.		4c. Cou	nty of Death	A place (State or Foreign
	Director			M2□F 65	A.f. makle	s Days	Hours Min.	Month, Day		Coun	try) Virginia
	the Marylan or 28a-f sh be notified a	I Director	Mayland NIA 10e. Street and Number	- 1 1			imore		10g. Citizen	of What Cour	0d. Inside City Limits 1
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiems 22 a or 28a-f show important: If tiems 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Two If Yes, Give Year or Dates.	If Yes, sp	edent of Hi	spanic Origin? (Sp Mexican, Puerto	pecify Yes or No- p Rican, etc.)		Race - Americ Black, White, Sify: Bla	
21215-0036	l within 72 hour /giene. ner than "natu t, the Medical	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		life. DO NOT u	∕ork done d	uring most of wor	king	1	f Business Ind	dustry
Maryland	should be filed and Mental Hy 7 is marked ott raumatic even	To Be	17. Father's Name (First, Middle, Last) Rando A Young	Print			18. Mother's Nan	Mapp			2/20/2
	of Health and of Health and fitem 27 is m		19a. Informant's Name/Relationship (Type 20a. Methodof Disposition 1 Burial 2 Cremation 3 Re	20b. Pla	19b. Mailing Addre 6429 W. ace of Disposition (N metery, crematory or	althe ame of	- Ave.	Apt D Date	Bat	on - City or To	Maryland
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Parky	e of Rut	h Cem	s of F lility Pa	20/10 Ker Fi	Accon	Hone	Virginia PA 21229
	Ph. sician/ Medical Examiner mial-transit	al Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a. Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	Atery noe of: DOSTALCTI	Dis	umna		lust		Approximate Interval Between Onset and Death
P.O. Box 68760	of the Hospital or Attending Physiciam: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and rompleted filled in by the funeral director, page 2 should be detached for use as the burial-transpace.	Physician/Medica	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnand 1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 🗌 Ectopio		/		1	Date of delive	ery Day Year
ds, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions conti	ibuting to death but not resul	iting in the underlying	g cause giv	en in Part I.				ne cause of death?
Division of Vital Records,	i cian: The law re certificate has be rector, page 2 sh	Completed						1 🗆 Yes		b. Were autopy prior to co death? 1 Yes	osy findings available mpletion of cause of
/ita	Physician; this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☑ €	R/Outpatient 3 □	I Otho	r:	lome 5 Resi	donas 6 🗆 C	Whor (Coosife	1
on of	ending Phy eath. or: After thi he funeral	Certificate: 1	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work	at	28d. Describe			
Divisi	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completed filled in by the funer		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Toi	vn, State)		Route Number,
	o the Hos vithin 24 ho o the Fune	Medical	(Check 2 Medical Examine)	an: To the best of my knowled on the basis of examination a Practioner: To the best of my k	and/or investigation, i knowledge, death occ	n my opinio	n, death occurred a time, date and pla	at the time, date	and place, and	due to the cau manner as st	use(s) and manner stated. ated.
	->-0		Matricia 9	in Oleno D		Hoo	6899Ce		Februa	_	
			30. Name and address of person who com		23a) (Type, Print)					1	1
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	maritan I		ar, pal	ıшore,	ענז		
	Registra	ir	FFR 1 72	1111 Vanne	1. 10 al						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03946 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 7:45 Edward N. McDowell February 11 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Care Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1**XX** M 2 □ F Hours July 10 ay, 1926 83 Michidan Director 380-16-8775 Usual Residence of Decedent show 10a. State 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sh notified a MD Halethorpe Baltimore 1 Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 4023 Hollins Ferry Road 21227 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, rmed Forces?

No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates WW I I Specify: Completed 3 XXWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other tha Machinist General Motors permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William McDowell Cecelia Jandron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Mott / Granddaughter 3203 Garden Ave. Baltimore, MD 21227 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Feb. 16, 2010 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility 5305 Harford Rd. Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ 996 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and shed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Unknown 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes ☐ Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K150259 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) Timonium MD 21093 CRN 2300 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** FEBRUARY 2010 EDNA LOUISE MORRISON 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2006 Summit Ave. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 □ M 2 🔀 F Months Hours Min Director 9, 223-42-3656 1934 Virginia Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Marylan lith and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Event as the neithed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Director Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2006 Summit Avenue 21237 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Completed by Specify. Specify 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Ments Important; If item 27 is marked any injury or other traumatic expenses the straumatic e 2 Edna Frances White Dewey (nmn) Vance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7956 Eastdale Road, Baltimore, MD 21224 Edna Kohl / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-11-10 Harford Memorial Gdn. Aberdeen, Maryland 21. Signature of Uneral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Stag **Physician** nd disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: , d in by the f within 24 hours after dea To the Funeral Directo completely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

۵. Records, The of Vital Division Hospital or Attending

Box 68760,

Ö

Baltimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

Delia Chiaramonte 11311 McCormick MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gilchnst

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD0057373

Hospile

Hunt Valley,

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December 1 State Prince Made Load Prince December 1 P	adley Magnes	S	State of Maryland / Department of 1- For State Registrar Certificate of Certifica			Reg. No. 2010	03948	
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State Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one claste on each line. Approximate interval detection of the classes of control disease or conclined in each list.	Salt ermit. Separti mporti						•	
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THE THE CACHE THE OX CELLUTION THE THE CACHE THE OX CELLUTION THE CACHE THE OX CELLU			failure. List only one cause on each line.		o or roop natory and	iou, chook, or hour	Between Onset and	
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Third of the composition of the cause of death of the cause of dea	876 tificat ing ph as the	<u>₹</u>	23b. Was decedent pregnant in the	etal death 3 Ectopic preg	gnancy			
Third of the composition of the cause of death of the cause of dea	ath cel	Sici	4 Pregnant at time of death 5 0	ther (Specify)				
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) February 12, 2010 30. Name and address of person whit completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner State Registrar 31 Date filed (Month, Day, Year) 29c. License number O.C.M.E. February 12, 2010 32. R gistrar's Signature ORIGINAL ORIGINAL OCME	the de	Phy		underlying cause given in Part I	23e. Did to	obacco use contribute to	the cause of death?	
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) February 12, 2010 30. Name and address of person whit completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner State Registrar 31. Date filed (Month, Day, Year) PHMH 17 Rev 1/2001 ORIGINAL OCME	P.C	ğ			1 Ye	s 2 No 3 Prol	pabiy 4 🗸 Unknown	
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30. Name and address of person whit completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 2010 32. R gistrar's Signature PHMH 17 Rev 1/2001 ORIGINAL OCME	5 ½ ½ 5	ğ		29c. License number		29d. Date signed (Mo.	nth, Day, Year)	
Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar DHMH 17 Rev 1/2001 Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Righter's Signature ORIGINAL OCME			Wy Cot my	O.C.M.E.		February 12, 201	0	
State Registrar 2010 32. Rigistrar's Signature ORIGINAL OCME	\sim	}	30. Name and address of person who completed cause of death (Item 23a)					
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DHMH 17 Rev 1/2001 ORIGINAL OCME		ate rar	31 Date filed (Month, Day, Year) 32. Rigistrar's Signature					
	DHMH 17 Rev 1/20			L	(DCME		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

Shis le Mc Drmott Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Pyramid Way 6746 Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗗 F Months Days Hours Min. 76 036-22-0231 Director 27, Aug. 1933 RΙ Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Mudical Examiner must be notified at Director Howard Columbia 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6746 21044 USA Pyramid Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify 2 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) event, the s 1 and 2 should be filed winty Health and Mental Hygier item 27 is marked other thother traumatic event, Inc. 12 Manager State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Albert Higginson Dorothy Louise Borders ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pyramid Way, Columbia, MD 21044 Albert J. Morris If item 27 or other t Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 2/16/2010 Final Journey Crem. Woodbine, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorpta Marshall PO Box 1413, Baltimore, MD 21203 Mai Mall 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☒No 5 ☐ Other (specify) the 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perforn 1 ∐Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury . Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? Natural Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MTCHAFI. VERNON MURPHY February 10,2010 10AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4602 Schenlev Road Baltimore NONE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8 Date of Birth 9. Birthplace (State or Foreign **X**▼ M 2 □ F Months Days Hours Min. 62 Feb°28.4947 Wastrington DC 216-50-9968 Director Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f Maryland None baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4602 Schenley Road 21210 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? or. Black, White, etc. ò 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes a No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 XX Divorced Specify Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Architect. Private Practice Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Vernon Murphy Margery Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 North Charles Street Suite 206 Balto MD 21201 John C Murphy Brother Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St Mary's Cemetery 4 Donation 5 Other (Specify) 2/17/10 Baltimore, Maryland nature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Drobab Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for es e consciouence ch cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death2 ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has page 2 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 🗌 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗆 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier W 1)57169 2010 of person who completed cause of death (Item 23a) (Type, Print) 21093 1407 15 31. Date filed 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 7,2010 2:58A. M Henry Mazan, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours NOV1 4 1942 Marwland 212-44-3500 67 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore City 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2616 Fait Avenue 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 V Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 hours after 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) 12th Bayview Medical Ctt Security Be Department of Health and Montal H Important: If item 27 is marked out any injury or other trainments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Mazan, Sr. Rose E. Hajewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Camellia Road Nottingham, Md. 21236 Dorothy Tana / Cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cem. February 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 16, 2010 Baltimore, Maryland 22. Name and Address of Facility aczorowski Funeral Home, P.A Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ the osavetma et astautic disease or condition nantus Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Dusito (or as a consequence of): if any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed k should be deta 23e. Did tobacco use contribute to the cause of death? þ Arten DISEASE Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension Wellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No CLYMUSIS certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 1 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 10701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

E. West

31. Date filed (Month, Day, Year)

D68286

Charles St Paltimore, NO 21204

29d. Date signed (Month, Day, Year)

2010

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Funeral

Director

28a-f show

ir than "natural", or items 23a or 28a-f shov the Madical Examinac must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, If a Nacial once.

Physician

/Medical Examiner

physician and s the burial-tran

attending p

been signed by the should be detached

certificate has birector, page 2 sl

funeral

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Stroke		1 Yes 2 No 3 Probably 4 Jnknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol	me 5 Residence 6 Other (Specify)
27. Manner of Death 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	n (Month, Day, Year) Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occurred and property of the	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29c. License number

DAKWOOD Pd. Glen Burnie MD 21061

29d. Date signed (Month, Day, Year)

State Registrar Muheres mD 1 7 2010

29b. Signature and title of certifier

30. Name and addre



m D s of person who completed cause of death (Item 23a) (Type, Print)

7845

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental / Lygione 2 0 | 0 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February ROBERT IRVIN NORWOOD 14,2010 3:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours Min Sept 2, 1932 **Director** 219-28-8286 Maryland Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Baltimore 1 ☐ Yes 2√X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 713 Anneslie Road 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? YX Yes 2 ^{rces}? No'53-'54 Black, White, etc. Completed by 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White 3 Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retai] Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Norwood Oma Stout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Redmon-Norwood Wife 713 Anneslie Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Donation 5 D Other (Specify) GreenMount Crematory 12/19/10 Baltimore, Maryland ion ture of Funèral Sec 22. Name and Address of Fathist chell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore. Marvland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line shock, or heart fallure. List only one Interval Between Perforated Viscus Immediate Cause (Final 1 2 Ponset and Death pronths Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 1½ months Ileus and Adhesions Sequentially list conditions, if any, each git in mediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed MINER attending physician and for use as the burial-tran CERTIFICATION APPROVED BY that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Other (specify) Pregnant at time of death Month Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tibia and Fibula Fractures Completed 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Di ath 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred **H**atural 5 Pending Accident 11/18/2009 9:00 a M Subject fell 1 Yes 2 X No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 713 Anneslie Road Baltimore, MD 21212 determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFR 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Physician/ Month 02 2010 Marie **Osborne** 12:12 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A Baltimore 3122 E. Northern Parkway Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 X F Month /03/11/917 212-10-3468 93 MD Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21214 3122 E. Northern Parkway Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Yes 2 X No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file Martin Miller James Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr Ellen Wagner, Daughter 159 Bourbon Court, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H 1 X Burial 2 Cremation 3 Removal from State 02/18/2010 4 Donation 5 Other (Specify) New Cathedral Baltimore, MD 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Derardu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ₹ 9 ☐ Unknown ed by the a detached t a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VASCULAV ACCIDENT Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The I
 24 hours after death.
 Funeral Director: After this certificate h 2 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 F No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending s after death.

I Director: Aff
d in by the fur Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a d title of certifier 29c. License number uuuu Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore Marylano 21210 5901 North CHArles Street Don m.7.

DHMH 17 Rev 7/2009

State

Registrar

Day, Year,

FEB 1 7 201

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Henry Gilmore Offney 5:15 PM FER 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BELAIR HEALTH AND REHABILATION CENTER HARFURD If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Min. 1 XM 2 □ F Hours 212-18-4034 10, 1921 Maryland 88 Dec. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Harford Bel Air Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 21015 USA 2115 Robertson Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ballistics Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles (nmn) Offney Elizabeth (nmn) Tribull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Robertson Road, Bel Air, Maryland, 21015 Charles E. Offney / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn, 2/9/2010 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Mias 23a. Part 1. Enter the disease, or complications that caused the death shock, or he in fail ire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown

2 🗆 No

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

10a State

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Funeral

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Funeral

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examines must be notified at

3altimore, Maryland 21215-0036

burial-transi To the Hospital or Attending Physician: hours after death. within 24 hours after death To the Funeral Director:

Physician/Medical

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Completed

Be

2

Certification:

Medical

31. Date filed (Month, Day, Year)

P.O. Box 68760

Records.

Vitai

Division of

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ∐Yes 2 XNO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D D56545

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615

32. Re istrar's Signature

State Registrar

npletely

DHMH 17 Rev 1/2001

W. MACPHAIL RD # 106, BEL AIR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 7, 8, perFH, G901, 3, 11, 2010, WS.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 4:50 AM 2010 Frank Washington Point 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore 5. Social Security Number ustaalt Savar 8. Date of Birthl 2/22/1922. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, **Funeral** Months Days 1 M 2 □ F 250-16-5706 86 87 Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or U.S.A.

14. Race - American Indian 8620 Kelso Drive Apt 202 21221 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No If Yes, Give Year or Dates: ortant: If item 27 is marked other than "natural", or items Injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married laryland 21215-0036 1 ☐ Yes 2 【No Specify. Specify: Be Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 tal Hygiene. Reliable Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Warehouse Foreman Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental em 27 is marked o Pages 1 and 2 should be ٩ Esaw Point Laura Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelso Drive Apt 202, Essex, Md 21221 Ora L. Point-Wife permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 2/26/10 Owings Mills, Md Signature Funeral Service Licensee Marchad Ady ss of Facility t Farmer \$104 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): **Physician** /Medical bangrinous Chol Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine law requires that the death certificate be executed burial-transit Anemic and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be <u>Demento</u> 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00055171 114/2010 N.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore MD 21237 DY-SEBASTIAN JIHN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Februan 131,4 M **Physician** atherine 16 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number last birthday) **Funeral** Days Min 1 M 2 urland 220-52-3623 60 march 28 na Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits Show 1 Yes 2 No **Funeral Director** ma. must be notified 28a-f 10g, Citizen of What Country 10e. Street and Number ō 382 23a (death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: items Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 2 No 1 🗌 Yes la ģ Specify: 3 Widowed 4 Divorced "natural". Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)/ MAXIMUM other than vent, the Me Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type. Print) Alamein aughter · Lawrence ande 27 other If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ð Cremation 3 Removal from State 1 Burial 2) permit. Page Department of Important: If any injury or once. 5 Other (Specify) 4 Dohation 21. Signa ure of Funeral Service Licensee 22 Name and Address of F 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode dying, such as cardiac or respiratory arrest shock, or heart value. List only one cause on each line. Onset and Death Immediate Cause (Final disease or conditi Stroke Ischemic Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) d by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has buildirector, page 2 sl autopsy performed 25 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 3 🗆 DOA 2 00 1 Inpatient 4 - Nursing Home 2 ER/Outpatient 5 Residence 6 Other (Specify) မ this 28c. Injury at Work? by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: 5 Pending investigation (Month, Day Director: After Watural 1 Yes 2 No ☐ Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral D
completely filled i the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 February 16, 2010 romes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 MD Katherine parke 's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Marie C. Piazzola 9:15 A. Medical February 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 607 Shipley Road Anne Arundel Linthicum **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Hours Min. (Month, Day, Year) 07/15/1919 Director 181 07 9301 90 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Anne Arundel Linthicum 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 607 Shipley Road 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 11th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Giuseppe Calviello Antonia Iaquinta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Piazzola / Son 605 Shipley Road Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Sepulchre Cem. 02/19/2010 Montgomery County, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease of complications that caused shock, or heart fallure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final Physician/ Jascular accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events as a consequence of): the burial-transi the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Other (specify) Pregnant at time of death Day Year 1 ☐ Yes 2 ■ 9 ☐ Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 📝 N 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🖪 Residence 6 🗌 Other (Specify) 2 🗗 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury accurred Natural 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02 | 15 | 2010 death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

671

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Year **Physician** ()850 TER OT IAMES 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1044 Vena Lane Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F 215 74 3833 48 12/27/1961 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No Director Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1044 Vena Lane 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ∐Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Painter Painting Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James I. Potter Margie Lee Morris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Bees / sister 1721 Grandview Road Pasadena, Maryland 21122 (Unk)Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, MD Good Shepherd Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramerouske or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) LUNG MONTHS Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending pl for use as t signed by the a d be detached f certificate has birector, page 2 s rector: 1 24 hours after se Funeral Direct pletely filled in b To the Hospi within 24 hou To the Funer completely fil

Funeral

Director

show

must be notified at

Maryland

the

Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or?

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. important: if Item 27 Is marked other than "natural", or items: any Injury or other traumatic event, the Medical Examiner muone.

Physician

/Medical

Examiner

Sequentially list conditions, if any, leading to immediate cause. Find I flush dying Cause (Disease or injury that initiated events resulting in death) Last	b			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy r (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underly	ng cause given in Part I.		use contribute to the cause of death? □ No 3 □ Probably 4 □ Unknown
	-		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death		101-115
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hom	ne 5 Residence	6 Other (Specify) TOME
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Value of the second of the sec	28c. Injury at Work? 1 □ Yes 2 □ No	8d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		ctory, office 2	8f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
	miner: On the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier	1 2 /	29c. License number	29d. D	ate signed (Month, Day, Year)

State Registrar

WW 445 MICHAEL 31. Date filed (Month, Day, Year) 82. Registrar's Signatur FEB 1 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FENSE HIGHWAY ANNAPOLIS MDZ1401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician JOHN** E. PAYNE JR. 2010 P^{M} February 6:48 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth Month, Day, Feb. 16, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Min 214-50-1417 Days Hours Mary Land Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Linthicum Heights Director Maryland Anne Arundel 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 21090 6 Boulevard Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐Yes 2 No Specify. Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician Allied 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Marshall Audrey John E. Payne Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Boulevard Place, Linthicum Heights, Maryland 21090 19a. Informant's Name/Relationship (Type. Print) Eileen J. Payne (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland Feb. 16, 2010 21. Signature of Fu and Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EVERE SERSI diate Cause (Final disease or condition resulting in death) 23d. Date of delivery Month Day Year use contribute to the cause of death? ☐ No 3☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠ No 6 ☐ Other (Specify) nd Number or Rural Route Number,

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate

Funeral

Director

show

d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at

'natural", or

permit. Pages 1 and 2 should be filed witt Department of Health and Mental Hygienn Important; if item 27 is marked other that any lulury or other traumatic event, the once.

Physician

Exam

with the Maryland

Baltimore, Maryland 21215-0036

Payne, John

/Medical Examiner	-	resulting in death)	Due to (or as a consequence of):		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of). C. — Due to (or as a consequence of):		
death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Yo
ician: The law requires man the of serificate has been signed by the ector, page 2 should be detached Be Completed by Physic		1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of de
		Puma	MYELINS MARY HYPERTONSION DMYOCATHY	24a. Was an autopsy performed?	24b. Were autopsy findings a prior to completion of ca death?
		25. Was case referred to medical examiner? 1 ☐ Yes 2 No	26. Place of Death		
Io the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	27. Manner of Death 1 M Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatio 6 Could not b determined	(Month, Day, Year) Injury Work? 1 □ Yes 2 □ No	28d. Describe how inju 28f. Location <i>(Street a</i> <i>City or Town, Stat</i>	and Number or Rural Route Numb
the Hospita hin 24 hours the Funeral mpletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Plants (Check only one)		and due to the cause(red at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
or this	ž	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)

Registrar

State

35 Monta Char

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Ruth Virginia Patrick 2015 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner De Grace Nursing 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🔀 F Director 215-82-1033 96 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 Wynmar Ave 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No Specify. 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harrison Brown Jenny Johnson . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy Hamm / Nephew 664 Stansberry Rd, Lansing, N.C. 28643 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State competer, crematory or other place)
W.Nottingham Cemetery 2/19/2010 1 X Burial 2 Cremation 3 Removal from State ö Department of Important: If any injury or Maryland Colora, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, 333 S. Parke St., Aberdeen, N 21. Signat Juneral Say Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed that initiated events Due to (as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires Records, 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No Vital completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) of 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After or Attending work?
1 Yes 2 No Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 🗸 🔾 🚶 🔱 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21:40 PM 2010 Februari Rutkowski Paul Walter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square Hospital Kosedale 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🌠 M 2 🗆 F Months Days Hours Min. (Month, Day, Year / 30 / 1937 Mary Land **Director** 219-32-7847 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shorms must be notified at Director 1 ☐ Yes 2 🕅 No Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1031 Foxcroft Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status "natural", or iter Armed Forces?

1 Ves 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1964 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 1966 White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Steel Mill Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out, any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maichrzak Rutkowski Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Louise Rutkowski (Wife) 1031 Foxcroft Lane Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 2618 4 ☐ Donation 5 ☐ Other (Specify) Heart of Jesus Cem Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Infarction vocardial disease or condition)- Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760 as t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? Yes 2 No Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tyes NER/Outpatient 3 ☐ DOA ပ္ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending n 24 hours after death.

le Funeral Director: After bleted filled in by the fur Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signati person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9000 Franklin 31. Date filed (Mont) Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Yeer Physician 145 PM 2010 se the Road /Medical Colorsvelle 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4d 21228 Buch Nusma 5743 Edwarden Acc If Under 1 Year | If Under 24 Hrs. eway Mary Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Hours 213-30-4496 Yrs Director -12-1933 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23s or 28a-f show Examinat must be notified at 1 ☐ Yes 2 No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9009 Samoset Road USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American Š 3X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry ad other than "I event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) 12th Cashier Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked ott jury or other traumatic even Herman Hardee Annie Dora Stancil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tanya D. Smith/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Lo 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 2-22-2010 * 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cameterv Woodlawn, MD 21. Sign ware of Funeral Service Licensee 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Whiple /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Iransit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-f Box 68760. Completed by Physician/Medical the t as esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 Day in the past 12 months? Month 5 ☐ Other (specify) signed by the al 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Hyperterner Attownshie Corners 1 Yes 2 No 3 Probably 4 Unknown 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P1966 2-13-2010

DHMH 17 Rev 1/2001

State

Registrar

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32. Fiegistrar's Signature

warren)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - mor 710

weekel

FEB 17 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Dav Month Physician Year ebruar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CARE IRVINGTON BALTIMORE TURE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 K F 564 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Tyes 2 □ No Director 1 or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 11. Marital Status Black White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 ⊋Ńo 1 ☐ Yes Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) edical permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other trainment. 2-16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) emina aren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ous Me 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) o Cremalor 5 ☐ Other (Specify) Name and Address of acility 3 21. Signal of Funeral Service Licen Marcy M. wa elac 23a. Part 1. Enter the civease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart is ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F n I disease or condition resulting in death) HALOPAT ENCE **Physician** /Medical Due to (or as a consequence of): Examiner Unknown HUMAN IMMUNODEFICIENCY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending properties of the second se IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 No ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Mo 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760 P.0. Records, Division of Vital

e Hospital or Attending Physician: The I 124 hours after death. e Funeral Director: After this certificate ha letely filled in by the funeral director, page Medical completely

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifigi

29c. License number 0006586 29d. Date signed (Month, Day, Year)

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERRY PD BALTIMORE

and manner stated.

14AMMONDS AWAN HASAN 31. Date filed (Month, Day, Year) Registrar's

State Registrar

within 2

driane L. Rich	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death									
Physic	ion/	Registrar 1. Decedent's Name (First, Midd	lo I set\		Tillicate of	Deam		2. Date of Dear	eg. No.	U U U J U
Physic ledical Exam		Adriane Lee R	ichardson					Month January 3	Day Year 0, 2010	3. Time of Death 0408 hrs
		4a. Facility Name (if not institution Upper Chesapeake M		mber)	i.	b. City, Town, or Lo Bel Air	ocation of Dea	ath	4c. County of Dea Harford	ıth
Funeral		Social Security Number		7. Age (In yrs. I	ast hirthday)	If Under 1 Year	If Under 24F	Irs 8 Date of Bir	th(MM/DD/YYYY) 9. B	irtholace (State or
Director		216-04-7994	1 M 2 X F	26	Yrs	Months Days		lin.	Fore	
_	1	Usual Residence of Decedent						1000.	.57 1505	
d now any	١.	10a, State 10b. County	C 7		Town or Locati					10d. Inside City Limits 1 Yes 2 X No
215-0036 be filed within 72 hours after death with the Maryland and Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	Maryland Ho	arford	<u>Dar</u>	lingtor	10f. Zip Code		10	Og. Citizen of What Co	
death with the More teems 23a or 2 nust be notified	牆	4008 Conowing	n Road			21034			USA	•
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r deatl	[문		1 Yes	2 X No		es, specify Cuban, N		to Rican, etc.)	White, etc.	
rs afte ural",	<u>ā</u>	3 Widowed 4 Div	orced If Yes, Give Year or Dates:			Yes 2 No :		f work done	Specify: Whi	
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c a de d	o Be	Robert Conley 19a. Informant's Name/Relations	Richardso	n Jr.	19h Mailing	Address (Street a	Laura C	Jayne Ros	e ber, City or Town, Stat	7:0 1)
e, MD 21 I and 2 should Health and Me Fitem 27 is mai		Laura J. Duni							ber, city or Town, Stat 1, MD 21040	
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Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other St		an otate	1+on Se	erpiace) ervice Cor	m 2-	-8-10	Towson,	Marriand
altii rmit spartm sporta jury o	10	21. Signatur of F eral Service	icens	11111	22. N	ame and Address of	Facility	Ioma D 7	TOWSOIT,	Maryland
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	ian/Mec	IF FEMALE:		utcome of pregr		eim, E gy	30 2/10	5/10 11	23d. Date of deliver	у
Sox 68760 death certificate b e attending physic	cian	23b. Was decedent pregnant in th past 12 months?	I LIVE DII	rth int at time of dea	ath -		Ectopic pregr	nancy	Month	Day Year
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 V Unk			⊃ [Oth	er (Specify)	<u>-</u> -			
of Vital Records, P.O. Bing Physician: The law requires that the de After this certificate has been signed by the luneral director, page 2 should be detached it	by P	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the ur	derlying cause give	n in Part I.		pacco use contribute to	
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of V ig Phy frer th	٦: ح	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury	28b. Time of In				ow injury occurred	
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Division of Vital To the Hospital or Attending Physician: within 24 hours after datte. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	(Check only Certifying Ph	niner:On the basis of	examination an	e, death occurre d/or investigation	ed at the time, date a in, in my opinion, de	and place, and eath occurred	d due to the cause at the time, date ar	(s) and manner as stated of the control of the cont	ed. e cause(s)
To To cor.	Me	29b. Signature and title of certifier	and manner sta	ited.		29c. License no			29d. Date signed (Mo	
		Parieth Douthall	M			O.C.M.E	E.		January 30, 2010	
ØV.		30. Name and address of person						45.0		
F	لب	Pamela E. Southall, M				Penn Street, E	Baltimore, I	MD 21201		
St	tate	31. Date filed (Month, Dan Year)	010	istrar's Signatu	back	and a				

10-01136 Ashton Ryan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

shton Ryan		1- For State	ate of Maryla		artment of rtificate of		and Ment	tal Hy		g. No. 20	10	03966
Physic	ian/	Registrar 1. Decedent's Name (First, Middle)	e,Last)					12	2. Date of Deatl	1		3. Time of Death
Medical Exam		Ashton Rya	an						Month February 7	Day Year 7, 2010		2305 hrs
		4a. Facility Name (if not institutio	-	ımber)	4		wn, or Location o	of Death		4c. County of		,
		Good Samaritan Hosp	oital			Baltimo				N/A		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1	1 Year If Unde Days Hours	r 24Hrs. Min.	8. Date of Birt	h(MM/DD/YYYY)		
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5-0036 Ted within 77 Hygiene. I other than othe Medical	Com	17. Father's Name (First, Middle,	Last)		Lxecu	tive		s Name (First, Middle, M	laiden Surname)	at	6
21215-00 uld be filed wit Mental Hygien marked other	Be	James Swee	, ⊇n v				Sa	rah	Chamb	ers		
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	1111	20a. Method of Disposition		20b.	Diago of Diagos	tion (Namo	of cemetery,		Date	20c. Location - 0	City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation		om State Cr	crematory or other ownsvil.	le_Vet	Cem.	$\frac{23}{2}$	3/2010	Owings	VII.	le ills, Md.
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Balti permit. Departn Imports		1/2	14.17	W		δ^{p}_{E}	Brothe:	rs I	Tunera Balt	l Servi imore,	Сe	. 21217
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Distance of the state of the st	Certification:		mined (Specify)					9	or Town, St 110 Chesley	^{ate)} Avenue, Baltim	ore Ci	ity, MD
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	1 8	30. Name and address of person	who completed caus	se of death (Item	1 23a)					ebruary	0,	2010
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	state	31 Date filed (Month, Day, Year)	32 Re	egistrar's Sonati	ure 🖉	a a				-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Kobentson 2:56AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Medico Hopkins Barview Baltimore, (ente MD Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Hours Apr 21, 218-44-8375 63 Director Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 10d. Inside City Limits 1 Yes 2 X No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7967 St. Monica Drive 21222 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4x Divorced Specify. Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th <u>Home Maker</u> <u>Own</u> Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Mazan, Sr. Margaret Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Icenrode/Daughter 7967 St. Monica Drive, Dundalk, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Oak Lawn Cemetery! 9,2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Physician Onset and Death neumonta disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed?/ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 1 Natient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred ✓ Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one the 29b. Signatur 29d. Date signed (Month, Day, Year) Physician of person who completed cause of death (Item 23a) (Type, Prin

Registrar

State

Stanley
31. Date filed (Month, Day, Year)

7

32. Registrar's Sig

Baltomore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Smith CLARA 2-35 PN 02 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ivy Hall Geriatric Center Baltimore Middle River 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 1√2 F 170 18 9790 May 5, 1912 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2☐No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Whitethorn Way 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Hetterman Mary E. Hebner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Poletynski (Daughter) 48 Dogwood Drive Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Christian Cem. 2/15/2010 Artemas, Pennsylvania 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as Honsequence of): disease or condition resulting in death) resellar Phoke Due to (or as a consequence): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Good ontesto Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 4☐Pregnant at time of death 9☐Unknown 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Joint Diseare 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 146 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

hysician Medical Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of cerlifier

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

Completed by

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

the burial-tran physician use signed by t page 2 certificate

funeral director, the f

Physician: After this Attending death within 24 hours after death To the Funeral Director: ō

Division or Vital Records, P.O. Box 68760,

filled in by

State Registrar

completely

the

821 N. EUTAW ST Shite 3 Nd BALTIMORE MD 21201 SHOALL A. HASHMI MD, 31. Date filed (Month, Day, Year) 32) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31464

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, c, perFH, G900, 2/23/2010, WS

State of Maryland / Department of Health and Mental Hygiene 03969 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Year Rosemary Scott 2132 /Medical Druciry 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Months Days Hours Year) Director 23 212-74-0136 58 MD Usual Residence of Decedent 10b. County 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination into the indiffed at Director MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4002 West Franklin Street 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Flementary/Secondary (0-12) Medical Photographer Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Joe Columbus Nettles Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 4002 West Franklin Street, Baltimore, Owen Scott-Husband 20b. Place of Disposition (Name of Loudon's Parkey or other place)
Arbutus Memorial 20a. Method of Disposition 20c. Location - City or Town, State **Baltimore** Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/10 Arbutus, Name and Address of Fach FAH Woodsh 21. Signatu of:Funeral Service Licensee 4368 est Ave, Baltimore, Md 21215 23a. Part 1/Enter the disease, or complications that caulsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dian to for each consciouence of and burial-trai Due to (or as a consequence of) Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregpant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify). 1 □ Yes 2 🗖 No signed by the 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No certificate 2 1 MG 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 28d. Describe how injury occurred 5 Pending investigation 1 atural death. 1 ☐ Yes 2 ☐ No Director: , 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) BP9619430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mary lund Sanjay Pattani 900 South Caton Aronne. Bultimore. MO 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 09 M SAUNDERS 02 2010 JAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL MONTGOMERY BETHESDA NAVAL MEDICAL CENTER MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F 54 MD 220-64-9521 Director MAY ZI Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Laurel MD Prince George 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number pe d ns 23a must b 20707 IISA 14116 Riverbirch Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>}</u> Special Frican-American 3 ☐ Widowed 4 ☐ Divorced Completed the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Health & Human Svcs. Project Manager 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delia E. Vaughn ို James Edward Saunders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tawana A. Saunders/Wife 14116 Riverbirch Court, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville Veterans Cam. 2-23-2010 Crownsville, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. ire of Funeral/Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** T-cell Lymphoma 1 Month disease or condition resulting in death) /Medical Due to (or as a conse ueno of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7. Tyen, MD Physician 0101051315 FEB 2010

121

State 31. Date filed (Month, Day, Year)
Registrar

JANET N. MYERS



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

BETHESDA, MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:39 AM Edward Summerfield 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medrcal Conta Baltrmore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** 1X□XM 2 □ F Months Days Hours Min. (Month Day, Year) 03-04-36 213-32-5574 73 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Saratogo Street Apt. 751 W. 21201 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. African ð 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates ^{Specify:} American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Maryland Shipyard and Dry Dock Elementary/Seconday (0-12) 10th Grade Laborer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည Summerfield, Sr. Ruth Lane Edward permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120119a. Informant's Name/Relationship (Type, Print) 751 W. #106 Baltimore, MD Beverly Summerfield-Wife Saratogo St. Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem. 02-18-10 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home MD 21217 638 N. Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Tricospid Requisitation Severe Mitual Stenosis. disease or condition Medical resulting in death) Examiner cardioutyopathy Leading decompensated Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician all the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myeloma 1 Yes 2 No 3 Probably 4 Yunknown Multiple 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No page certificate 2 1 No 26. Place of Death (Check only one) a B 25. Was case referred to medical Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Tyes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ol or Attending F safter death. 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director; Aft leted filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) MD 1811122740 2/13/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Kim, MD Mary land Greens 31. Date filed (Month, Day, 32. egistrar's Signatur State FEB 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 10,2010 0054 М <u>Helen A.</u> Stewart 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Balto. Gilchrist Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 217-20-8463 1 □ M 2 🗓 F Months Days Hours Min. October 10,1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Balto. Nottingham 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 9537 Bauer Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: White 3 Xwidowed 4 ☐ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bank Teller 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Pencek Emelia Krupa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, Md. 21047 Son 2822 Cross Country Ct. Lester Stewart 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0aklawn 2-16-2010 Balto. Md. 21224 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death preumonia disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

s been signed by should be detac his certificate has b I director, page 2 sl within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

Physician/Medical Examiner	Sequentially list conditions, if any, both a trimed at cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):		yevs
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖟 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of de Month	elivery Day Year
Completed by P	Part II. Other significant conditions col	ntributing to death but not resulting in the underlying cause given in Part I.	24a. Was an autopsy performed? 24b. Were at prior to death?	o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of the cause of
Be (25. Was case referred to medical examiner?	26. Place of Death (Check of		
일	1 Yes 2 No	ospital:	ne 5 Residence 6 Other (Spec	OITY MARDICA
	27. Manner of Deat 1 M Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	00 - D-1 (1-1 00 T) (8d. Describe how injury occurred	7.4
Medical Certificate:	4 Homicide determined	building, etc. (Specify)	8f. Location (Street and Number or Ru City or Town, State)	
Medic	Check / 2 □ Medical Examin	cian: To the best of my knowledge, death occured at the time, date and place, and er: On the basis of examination and/or investigation, in my opinion, death occurred at the Practioner: To the best of my knowledge, death occurred at the time, date and place,	he time date and place, and due to the	cause/e) and manner etater

29d Date signed (Month, Day, Year)
FLNevy 1/2010

Charles ST POWSON MA

State Registrar 29b. Signature and title of certifier

HARUN 31. Date filed (Month, Day,

1 7 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M)

6701 N

			Please	Type or Print in						
			1 - For State Registrar	State of Maryla		artment of F rtificate of I			ene g. No 2010	03973
	Physici	ian	1. Decedent's Name (First, Middle, La	william Benja	amin Soc	rolkon I	~	2. Date of Death Month	Day Year	3. Time of Death
- Walter	/Medio		4a. Facility Name (If not institution, give		allitii Seg		Location of Death	Februar	4c. County of Deat	
not.			Baltimore Washin 5. Social Security Number 6. S		Center	Glen	Burnie	0. D-1(D'.)	Anne Arı	
	Funeral Director		216 18 5099	1 M 2 F 88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 08/02/1	921 Mai	hplace (State or Foreign untry) Yland
	yland		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Ba-f st	Director	1102) 20110	Arundel	Linthic	um				1 Yes 2 No
	hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Evaninar roust by northed at	ral Dir	10e. Street and Number 123 N. Long Cro	ss Road		10f. Zip Code	.090	10	g. Citizen of What Co U.S.A.	untry?
	fter dea	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 1 Yes 2 No		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
0036	ural", or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give WW Year or Dates:	II 1	□Yes 2基 No	Specify:		Specify: W]	nite
21215-003	vithin 72 ane. t han "na	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	ducation ade completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired todian	ation during most of workii l)	ng 1	Baltimore	e County
ō	il Hyg other ent, I	Be Co	17. Father's Name (First, Middle, Last))	Cus	LOGIAN	18. Mother's Name	(First, Middle, Ma	Public Soliden Surname)	CHOOLS
ryland	should be fand Mental s marked o	2		William B. Se				ha Cantl		
, Mar	permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 is marked any Injury or other traumatic ev		19a. Informant's Name/Relationship (Sandra Kvech / D				ross Road		City or Town, State, 2 hicum, Mar	yland 21090
altimore,	ages 1 nt of He t: If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	rremoval nom state		sition (Name of atory or other place	i .		Oc. Location - City or	
altlu	rmit. Papartme portant portant y Injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer			Veteran (Name and Addres	(F		Crownsville cal Service	e, Maryland
מ	8 2 E 8		Jeiome Zn	onceour			nie Highwa	ay Balti	more, Mary	yland 21225
1	Physician		23a. Part 1. Enter the disease or compshock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.	The same of the sa	er the mode of dying	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
j	/Medical Examiner		resulting in death)	a. Due to (on as a conse	A	en i	a regre			
	₽ #	ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	quence of):	tery	01500	50	-	
	eath certificate be executed attending physician and for use as the burial-transit	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	equence of);					
00/00	ate be hysiciar he buri	lical E		d						
YOU !	certific nding p	sician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy				Old Date of deli	
5	e death the atte	sicial	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
	uires that the de signed by the a d be detached t	y Phys	9 ☐ Unknown Part II. Other significant conditions or		suiting in the un-	derlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
20.0	w requires s been sign should be	ted by					100 1100	1 □ Yes	2 No 3 Pro	obably 4 Unknown
ער		Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
<u> </u>	Physician: The la r this certificate har ral director, page 2	Be Co	25. Was case referred to medical examiner?				26. Place of Death	1 □Yes 2√	ZNo 1 ☐ Yes	2 🗆 No
5 6	Physic rthis co	၉	1 Yes 2 No 27. Manger of Death	Hospital: 1 Inpatient 2 [28a. Date of Injury	ER/Outpatient	3 ☐ DOA Othe	4 LI Nursing Hon		ce 6 ☐ Other (Spec	ify)
5	Attending Ph death. ctor: After th y the funeral	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year)	Injury	Work'	? ′es 2 □ No	8d. Describe how	injury occurred	
	to the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, stree sify)	et, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	ne Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example 1	ysician: To the best of my kr liner: On the basis of examir and manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)
	vith Com	Σ	29b. Signature and title of certifier			29c. License	number	290 Fo	Date signed (Month	Day, Year) 14 2010
		-	30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type, P	rint)	0112	,	1	
	Stat		A DEM I PO S (31. Date filed (Month), Day, Year)	ADEGBUL 32. Registrar's Sign	UGBE	301 #0	spital De	ive, Glan	Burnie.	mo 2061.
	Stat	е	or. Date med (wells, day, real)	32. Registrar's Sign	ature					

Registrar DHMH 17 Rev 1/2001 31. Date filed (Worth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 12:16 PM WILLIAM **JAMES** SIEBENHAAR 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** FEB. Day Year) 1926 1 □**X**M 2 □ F Hours Min MARYLAND Director 214-20-2084 83 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c City Town or Location 10d. Inside City Limits Director N/A 1X Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3221 FOSTER AVENUE 21224 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

Yes 2 \(\subseteq \text{No} \) Black, White, etc. 1 X Never Married 2 Married by 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 946-54 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 MECHANIC BETHLEHEM STEEL Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOSEPH SIEBENHAAR SR. DOERFLER BARBARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH SIEBENHAAR, JR/BROTHER FOSTER AVENUE, BALTIMORE, MD. 3221 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State HEART OF JESUS 4 ☐ Donation 5 ☐ Other (Specify) SACRED 2/18/10 BALTIMORE, MARYLAND 21. Signature of Full rvice Licensee Name and Address of Factorial LILLY & ZE 700 S. CON ZETLER INC. FUNERAL HOME CONKLING STREET, BALTO., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final Onset and Death Physician/ D. Just Luna disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1. Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending ours after death. 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completed fi (Check 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30, Name and address of person who

31. Date filed (Month, Day, Year)

Memori

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Beltimere

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Silverman Frances 7:15 a^M 2010 Feb Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Milford Manor Nursing & Rehab Cntr Pikesville, . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Yea 19/1917 1 🗆 M 2 🗓 F Months Days Hours Min 218-26-0598 92 Director Radford Usual Residence of Decedent show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2X No Pikesville MD Baltimore 0. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a (Examiner must be Funeral 21208 U.S.A. 16 Old Court Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 X Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edith James Howell Slusher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Silverman - son 4650 Alcott Way, Owings MI11s, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2010 Balt Hebrew Cem Reisterstown, MD 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Atheroselent Onset and Death Physician Cerebral Vasculer disease or condition resulting in death) 100-3 Medical Due to (or as a consequence of): Examiner Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Month Dav Year Pregnant at time of death the 9 Unknown g Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an performe funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 K Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 8,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MO Jef Zbell 2835 MO 21209 31. Date filed (Month, Day, Year)

State

Registrar

FEB 17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #11, per Fh g900 2/17/10 TT State of Maryland / Department of Health and Mental Hygiene \bigcirc 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Eme of 30th -Month **Physician** RHODA 1.200 STEINMAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner COURTLAND GARDENS BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/15/1915 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 X F Months Days Hours 219-42-1665 95 NY Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with th and Mental Hygiene.
7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 3408 GUILFORD TERRACE 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by Specify. 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER SOCIAL WORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (SAMUEL PERLO 2 RAY STEINMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID WEINBERG/SON permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 10705 EAST NOLCREST DRIVE, SILVER SPRING, MD 20903 27 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State HAR SINAI CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2/17/2010 BALTIMORE, MD 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to find solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, relied imeller acciden 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed:

1 Yes 2 No Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 10 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 31. Date filed (Month, Day, 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	within 72 hours after death with the Maryland liene. sr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Director	10a. State MD	10b. County	A	10c. Ci	ity, Town or Lo						10d. Inside City Limits 1 Yes 2 □ No
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Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ρ	1 X Never Marri 3 ☐ Widowed 4		ied Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	e	1	If Yes, specify Cuba		o Rican, etc.)		Black, Whit	
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Baltimore,	Page 1 ment of ant: If i		1 🔀 Burial 2 🛭 4 🔲 Donation	☐ Cremation	3 ☐ Removal from pecify)	State	Mt.	natory or other plac	· .	9/2010	i	altimor	
Balt	permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.	1	21. Signature of Fun	eral Service Li	censee	W	Ma	Name and Address Arch F/1 300 Waba	s of Facility				
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director and the funeral director.		IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		Birth 2☐ Fet ⊓ant at time of	al death 3	Ectopic pregnand Other (specify)	y		38	23d. Date of de Month	livery Day Year
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Divisio	tal or Attendi s after death al Director: A ed in by the f	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could r	28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (City or Tov			ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 only one) 3	☐ Medical Ex☐ Certifying	Physician: To the be caminer: On the bas Nurse Practioner: 1	s of examinatio	n and/or invest	igation, in my opinic	n, death occurred a	at the time date :	and place	and due to the	cause(s) and manner stated
	vit To 1			vic C	aliostm			29c. License	number		_	te signed <i>(Montf</i>	
			30. Name and addres	ss of person w	ho condeted caus Jan M	- 1.		rint) Hospital		صم بدرا			
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State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Taylor L. Georgia 02 15 2010 7:30a.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Year) 93 NC Director 238**-**98**-**6785 18 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Y Yes 2 □ No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 U.S.A. 3730 Songbird Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: Black \$ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic Worker 2nd Grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Launa William William Leak 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3730 Songbird Circle, Baltimore, Md 21227 Jessie Mallory-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/19/10 Halifax Co., NC Station Memorial 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sign ture of Funeral Service Licensee U. Truc Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2万No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 1 7 2010

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

BUSINESS CENTER DRIVE REISTERSTOWN MO 2/136 210 2. Registrar's Sign ture

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0059107 29d. Date signed (Month, Day, Year)

02-15-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year M 17:07 PM lown send 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Itop king Medical BALTIMORE 5. Social Security Number いれん If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min. (Month, Day, Year Director 58 Mary Land Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5600 Wilvan Avenue 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Lewis Townsend Susie Ewing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Ruffin 5600 Wilvan Avenue, Baltimore MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Ardent Crematory or other p 1 Burial 2 Cremation 3 Removal from State 2/17/2010 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Feneral Service Licensee 22. Name and Address of Facility Phillip A. Weatherford FS, P.A. 2431 East Oliver Street, Baltimore MD 21213 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Opset and Death Ph sician/ disease or condition resulting in death) diac Medical Due to (or as a consequence of) Examiner years oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) n signed by the a Ild be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings åvailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate I funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 1 X Natural Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) RES - 000 2010 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print)

State Registrar Bradler

31. Date filed (Month, Day, Year)

4940

Eastern

Baltimore

MD

21224

M.D.

Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3980 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Anthony Lee Thurman 12:58PM 02 13 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 TF 42 212-04-1906 Director MD Aug. 18, 1967 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Baltimore MD 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 3215 Bayonne Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married Black 1 ☐ Yes 2 XNo Specify: Completed by Specify: 3 Widowed 4 Divorced natural". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Pages 1 and 2 should be filed within " nent of Health and Mental Hygiene. int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Andrew Lee Thurman Jennelle Couch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1477 Falcon Nest Ct., Arnold, MD 21012 Verlencia Conyers / Sister Itimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Final Journey Crem. 2/16/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licens Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio my opeth Due to (or as a consequence of **Physician** disease or condition resulting in death) /Medical Examiner DEMMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). Examiner The law requires that the death certificate be executed Congestile Due to (or asia consequence of): burial-trar that initiated events and resulting in death) Last Division or Vital Records, P.O. Box 68760, physician Physician/Medical CHRONIC PENAL the attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) a∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obese 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? res 2 No certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending Injury 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

State

Registrar

29b. Signature

Terbert

31. Date filed (Month, Day,

N

DHMH 17 Rev 1/2001

M.D.

Registrar's Signature

29d. Date signed (Month, Day, Year)

.2123

and manner stated

and address of person who completed cause of death (Item 23a) (Type, Print)

triedman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month John Oliver Todd 8:00 Ам February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours Min. Month, Day, November 183-12-9793 88 Director 1921 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Baltimore Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21236 132 Lyndale Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Year or Dates. WW II white 3XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) foreman copper refinery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Todd Evelyn Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Granata/daughter 2910 Tweed Dr. 21048 Finksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNIZ 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Philipsburg Cemetery Philipsburg, Pennsylvania Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician, disease or condition resulting in death) emplications Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 1 Yes 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes Be 25. Was case referred to medical 28. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) After this 28c. Injury at work?
1 ☐ Yes Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accider 5 Pending 2 🗆 No Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/ar inventigation in my called the state of the cause of examination and/ar inventigation in my called the state of the cause of examination and/ar inventigation in my called the state of the cause of examination and/ar inventigation in my called the state of the cause of examination and/ar inventigation in my called the state of the cause of examination and/ar inventigation in my called the state of the cause of examination and/ar inventigation in my called the state of the cause of examination and the cause of exa 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Grace T. Umemoto 55 A 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4807 Chevy Chase Blvd. Montgomery Chevy Chase If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral Days 1 M 2 XF 1170771919 90 Director 053-18-9848 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 USA 4807 Chevy Chase Blvd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ★Widowed 4 ☐ Divorced Oriental Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important if item 27 is marked other than any Injury or other trainmets. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Administrator World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Shingoro Takemori Mitsue Ueda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4807 Chevy Chase Blvd., Chevy Chase, MD 20815 Mariene Lee/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 02/16/2010 Hanover, MD 21. Signature of Juneral Servicens Ardent Cremation Services rive, Ste. N., Hanover. M 7522 Connellev Drive. MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician month disease or condition Medical resulting in death) Due to (or as a conse vience Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autonsy performed? Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 4 Nursing Home 27. Manner of Deatl 28a. Date of injury 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 24 hours Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and 414,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larbin Garcia V		cillo State	of Maryland / Depai	tment of He	alth and Menta		DIG.	
		1- For State Registrar		ificate of De	ath	Reg	No. 2011	0 0398:
Physici Medical Exami		1. Decedent's Name (First, Middle, Last Marbin Ga	rcia Vall	lecillo	······································	2. Date of Death Month E February 11		3. Time of Death 1220 hrs
		4a. Facility Name (if not institution, give 10812 Reisterstown Road	estreet and number)		y, Town, or Location of I v ings Mills	Jeath	4c. County of Death Baltimore Cou	
Funeral Director		5. Social Security Number 6. Se 908-90-7651 Usual Residence of Decedent	/_ " ' '		Inder 1 Year If Under 2 Inths Days Hours	8. Date of Birth	MM/DD/YYYY) 9. Bir Foreig Co	
0036 within 72 hours after death with the Maryland jene. ter than "natural", or items 23a or 28a-f show any Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County 10c. Street and Number Sierra Ci 11. Marital Status 1 Never Married 2 Married	nore Ow 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	5. 13. Was Dec	Zip Code J1117 edent of Hispanic Origin ecify Cuban, Mexican, P	? (Specify Yes or No-	White, etc.	
P 2 5 5 9	Completed by	3 Widowed 4 Divorced 15. Decedent's Education (Specify on Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates: ly highest grade completed) College (1-4 or 5+) 5+	16a. Decedent's Us	2 No specify: Juli Occupation (Give kin working life. DO NOT us 18.Mather's l		Specify: La 6b. Kind of Business/ Au + Lum iden Surname)	Ain o Industry
nore, MD 2121: ages I and 2 should be file nt of Health and Mental It: If item 27 is marked other traumatic event,	To Be	19a. Informant's Name/Relationship (Type) 19a. Informant's Name/Relationship (Type) 20a. Method of Disposition	ia Son	19b. Mailing Addr	ess (Street and Number fa Circh	E #E. Owin	er, City or Town, State S. Mills Oc. Location - City or	MD21117
Baltimore, bermit. Pages I ar Department of Her Important: If ite	12	1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21 Signature of Funeral Service License	Removal from State cr	ematory or other pla	and Address of Facility	,	Rio Esteb	in Honduras
の を含点語 Physician	6 33	23a. Part I. Enger the disease, or compl	ications that caused the death.	8120	Liberty K	of Kandal	Istown, m	D 2//33 Approximate Interval
Medical Examiner	ŝ a	failure. List only one cause on ea	ch line. Head and Neck Injuries Due to (or as a consequence of)					Between Onset and Death
bd bsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Oue to (or as a consequence of)					
e executed cian and rial - transi		UNPENDED d.	AMENDED Item#15p	erFH COOO	2/17/2010	IJC		
Records, P.O. Box 68760, The law requires that the death certificate be executed trate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. Live birth Pregnant at time of dea	2 Fetal de	ath 3 Ectopic p		23d. Date of deliver Month	y Day Year
i, P.O. B ires that the d signed by the	þ	Part II. Other significant conditions	contributing to death but not re-	sulting in the underly	ring cause given in Part		2 No 3 Pro	the cause of death?
Division of Vital Records, tal or detains Physician: The law requir is after death. **I Director: After this certificate has been seled in by the funeral director, page 2 should I	Completed					24a Was an autopsy perform	prior to	utopsy findings available completion of cause of es 2 No
of Vital Ing Physician: After this certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 I	ER/Outpatient 3	26.Place of Death (C DOA Other 4 N		esidence 6 🗸 Othe	r: Scene
ion of tending Phyleath. tor: After title funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Feb 11, 2010	28b. Time of Injury 1203 hrs	28c. Injury at Work? 1 Yes 2 ✓ N	28d. Describe ho Subject believ equipment	w injury occurred red struck by por	tion of heavy
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor		ory, office building, etc.	or Town, Sta		ural Route Number, City Mills, MD
To the Howithin 24 Parto the Funcompletely	Medical	Torrect oray	an: To the best of my knowledge On the basis of examination an					
To with	Me	29b. Signature and title of certifier	and manner stated.	14	29c. License number O.C.M.E. 00		29d. Date signed (Mo	
2		30. Name and address of person who of Theodore M. King, Jr., MD			Penn Street, Balti	more. MD 21201		
S	tate trar	31. Date filed (Month, Cay Year)	32. F. gistra s Signatur					

ORIGINAL

Please Type of Printin Black Indelible 17k5 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 22:05 pm Edith H. Wilkins 2010 /Medical KENEUMRU 11 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Town, or Location of Death BALTIMORG If Under 1 Year | If Under 24 Hrs 5. Social Security Number Date of Birth (Month, Day, Yea 12-27-192 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours Yrs. Director 21.6-30-5599 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar oust to inclined at Completed by Funeral Director XXYes 2 □No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 1918 W. Balto. Street, Apt. A USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No specify: African-American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Caregiving 11th Private Duty Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be elvin Jones Margaret Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Tina Wilkins/ Daughter 1918 W. Balto. Street Apt. A, Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Cramatory 2-18-2010 Baltimore, MD permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wile Fineral Home P.A. of Barto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dicemia disease or condition resulting in death) tours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached it Division of Vital Records. P.O. 9 Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannew of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P22251 The MD Feb shory 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balkimore MD 900 S. aton Avenue 32. Registrar's Sig State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day₃ 2010 05:20 Waite Bessie Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 5106 Greenhill Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 1 - M 2 X F Min 07-26-1924 85 Marviand **Director** <u>219-22-3072</u> Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore N/A Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5106 Greenhill Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Waitress Restaurant Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Inglart Jav Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5106 Greenhill Avenue Baltimore, Maryland 21206 Betty Beaumont - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20c. Location - City or Town, State Date 2-16-2010 1 Burial 2 XCremation 3 Removal from State Hilltop Service Corp. Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature neral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician wileus un disease or condition resulting in death) Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical 2 Geis del mentid Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day signed by the ard d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 2 🗆 No Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, d eth undomed at the time. 29b. Signature and title of certifier

Registrar

State

Cotor
31. Date filed (Month

Moran Union Memorica Hospit-1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D000 8093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar	- Loot)			Cer	tificate	of De	eath		Reg.	No. 2	1	13986
	Physicia Medic		Decedent's Name (First, Middle		abetł	n Anı	ne -	Wein	ner		2. Date of Month Fe		Day 201	ear	3.4 interof Beath 0
	Examin	er	4a. Facility Name (if not institution	, give street and nu	mber)			4b. City, To	wn, or L	ocation of Dea	ath		4c. County of	Death	
ليمدي			7357 Geis		I					mere					e Co.
	Funeral Director		5. Social Security Number 219-04-4324	6. Sex 1 M 2 T	7. Age (II	n yrs. last birth	rday) Yrs.	If Under 1 Months D	year Days	If Under 24 Hi Hours Mi		Birth Day, Yea 26,1	968	Coun	place (State or Foreign try) yland
	nd now at	ī	Usual Residence of Decedent 10a. State 10b. County		11	0c. City, Town	or Loc	ation						1	0d. Inside City Limits
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	he Ma or 28 noti	Dire	MD Bal 10e. Street and Number	timore				10f. Zip Co		nere		10g	Citizen of Wh	at Coun	
	with t	Funeral Director	7357 Geise A	Venue						2121	9		ited S		•
	eath tems er mt	Fun	11. Marital Status	12. Was Dec		r in U.S.	13. W	as Decedent	of Hisp	anic Origin? (Specify Yes or N		14. Race -		
5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If You Ci	2 ဩ∏No ve)		Yes, specify			erto Rican, etc.)		Black, Specify:	White, و	etc. White
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<u>a</u>	2 sho th and 7 is r		19a. Informant's Name/Relations	17	usbar	.14	·	,			Rural Route Nun				,
	and Healt em 2		Mr. Keith S. 1 20a. Method of Disposition	<i>M</i> eimer, S		20b. Place of		Geise		e. Ed	gemere,		yland Location - C	212	
٥	age 1 ant of t: If it		1 🗆 Burial 2 😾 Cremation	3 Removal from			, crem	atory or othe	r place)	rn! 2/	10/2010				aryland
Baltimore,	nit. Pa artme ortan injur		21. Sign ture of Funeral Service		0	1111110	<u> </u>	Name and A			10/2010			•	- Jana
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of			e death. Do no	ot enter	r the mode o	dying,	such as cardi	ac or respiratory	arrest,			Approximate Interval Between
	Pnysician/	ì	Immediate Cause (Final disease or condition	_ a _ \ \ \ \ \ \	iver	Fail	w	<u></u>						2	Onset and Death
	Medical Examiner		resulting in death)	Due to	(or as a co	onsequence of	f):	Rison	1	- C-	W 100		42		(1 100-0
		e.	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a co	onsequence of	n.	2500	51	1 CC	naine	-VV	_	-	7 410025
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury	S Duc to	(0) 40 4 00	onocquenoc o	.,.								
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20	icate be executed physician and s the burial-transit	edical		d											
	tificat ng ph as th		IF FEMALE:												
o X	th cer tendii or use	ian/	23b. Was decedent pregnant in the past 12 months?		Birth 2	Fetal death		Ectopic pre					23d. Date		-
X D D	e deal the at hed fo	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unk		me of death	5 📙	Other (speci	fy)			_	Monti	1	Day Year
5	at the		Part II. Other significant condition	ons contributing to	death but r	not resulting in	the un	nderlying cau	se giver	n in Part I.	23e. Di	d tobacco	use contribi	ute to th	e cause of death?
S,	ires the signer of the signer	d by									. 1	☐ Yes	2 € No 3	☐ Prob	oably 4 🗆 Unknown
0	requ beer shou	lete									24a. W	as an	24b. We	re autop	osy findings available
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Ē	an: Tl tifical tor, pi	Be C	25. Was case referred to medical						6. Plac	e of Death (Ch		es 2 🔼	No 1 L	⊥ Yes	2 🗆 No
	nysici iis cer direc	일	examiner? 1 ☐ Yes 2 █ No	Hospital:	Inpatient	2 🗆 ER/Out	patient	3 🗆 DOA	Other:	4 Nursing	Home 5 XR	esidence	6 Other	Specify)	
Ö	ng Pt		27. Manner of Death 1	28a. Date (Mor	of injury oth, Day, Ye	(ear) 28b, Ti	me of jury		Injury a work?		28d. Describ	e how inj	ury occurred		
0	tendi death. for: A the fu	iţic	2 Accident Investi	gation not be						es 2 🗆 No					
DIVISION OF	al or At s after o I Direct d in by	Certificate:	4 Homicide determ	inod 28e. Place	e of Injury ing, etc. (S	- At home, fari Spec <i>ify)</i>	m, stree	et, factory, of	fice			n (Street a Town, Sta		or Rural .	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 ☐ Medical E	Physician: To the lixaminer: On the ba	sis of exam	nination and/or	investig	gation, in my	opinion,	death occurre	d at the time, dat	te and pla	ce, and due to	the cau	ise(s) and manner stated.
	o the		only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the bes	st of my knowle	edge, de		at the t cense n		place, and due to		e(s) and mann Date signed (f		
	F 5 F O		Dearles (adeothy				T	15	546		F	8 de	20	
	101		30. Name and address of person	who completed cau	se of deatl	h (Item 23a) (T	ype _n Pr				י לדד	1 1			
	Stat	0	Change Pada E	TT MD	56 Registrar's	Signature	ch	Kay	er	Blue	l, sa	ltin	wore,	Me) 21231
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		For State Registrar	State	e of Maryla		artment of H		•	giene Reg. No 20	10	03987
		Decedent's Name (First, Midd)	e, Last)					2. Date of De			3. Time of Death
Physici		ANNIE ELIZA	BETTH WYZ	رل مل ار				Month FEBRUAR	Day Y 8, 20	Year	6:10 P M
/Medio Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death		4c. County		0:10 P
		1711 Baldwin	Mill Ro	nad		Forest F	J:11		Harfo	bro	
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h		lace (State or Foreign
Director		216-22-4355	1 □ M 2 🛭	8!	9 Yrs.	Months Days	riouis wiiii,	Feb. 11	, 1920		yland
w w		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	cation					0d. Inside City Limits
faryla	5			100.						''	1 ☐ Yes 2 🛣 No
r 28a-f show	Director	Maryland Har 10e. Street and Number	ford		Forest	H111 10f. Zip Code		Т	10g. Citizen of V	What Cour	
ath with		1711 Baldwin	Mill Pos	- A		21050			USA	riac oour	
after death with the Maryland or items 23a or 28a-1 show riter rrust be notified at	Funeral	11. Marital Status	12. Was	Decedent Ever in		Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No		e - Americ	an Indian,
after or ite		1 ☐ Never Married 2 ☐ Mar	ried 1 🗆	ed Forces? ∕es 2 ⊠ No		If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Blac	k, White, e	
ours afte ral", or i	l by	3 Widowed 4 □ Divorced	Year	s, Give or Dates:		1∐Yes 2∏∑No	Specify:		Specify	Whit	æ
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ithin ne. han	Completed	Elementary/Secondary (0-12)		ge (1-4or 5+)	`life.	kind of work done o DO NOT use retired		9			
led w Hygie her ti		8	f ==4)			Homemake:		(Firet Middle	Own Ho		
l be fi	Be	17. Father's Name (First, Middle,	,				18. Mother's Nam			e)	
hould id Me mark matic	ျှ	Henry Harrison 19a. Informant's Name/Relations	-)	10b Mailie	ng Address (Street a		Ellen Mo		Ctata Zin	Codel
d2s Ithan 17isi trau		Connie M. Ques							-		- f
Hea Hea tem		20a. Method of Disposition	претту	··		711 Baldw: sition (Name of natory or other plac	ru Miti F	Date	est Hil. 20c. Location -	City or To	21050 wn, State
ages ent of it; If i		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		rom State		natory or other plac iew Cemet		3-10		•	Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, If a Medical Exa		21. Signature of Funeral Service	<u> </u>	1		Name and Address CCOMAS FU					Maryrand
permi Depar Impor any Ir		Atesta (Heer	14	5	0 W. Broa	nerar no adway, Be	al Air, I	MD 21014	Į.	
		23a. Part 1. Errier the disease, or shock, or heart failure. List	complication t	hat caused the de	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	only one cause		z-olipad	c Hear	(D):	2 1 1 11		ļ	Onset and Death
/Medical		resulting in death)	Du Du	e to (or as a cons		- (10-4		and desired			3)
Examiner	_	Sequentially list conditions,	b								
ted ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a cons	equence of):						
execu n and al-trar	xan	that initiated events resulting in death) Last	c	e to (or as a cons	equence of):						
cate be executed physician and the burlal-transit	dical E		d								
tificat g phy as the	edi		u	177							
h cer endin use	<u></u>	IF FEMALE: 23b. Was decedent pregnant		s, outcome of preg		Je			23d. Dat	te of delive	ery
e law requires that the death certific has been signed by the attending I e 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ NO	4 🗆 1	Live birth 2□Fe Pregnant at time o Unknown		Dectopic pregnancy Other (specify)			Мо	nth	Day Year
at the I by th	hys	9 ☐ Unknown									
es tha		Part II. Other significant conditi				nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ribute to th	ne cause of death?
equir een s ould	ted	- Denere	Paripl	rent Va	Sculin !	Destarion		1 🗆 \	′es 2 ☐ No	3 Prob	ably 4 thknown
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The cate h	Con							perfo 1 □ Yes	med?	death? I □Yes	
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hysi this o	ျှ	1 Yes 2 No		1 Inpatient 2			4 Li Nursing H	-	lence 6 Oth		y)
ling F	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	g (Date of Injury Month, Day, Year)	28b. Time of Injury	Work		28d. Describe h	ow injury occurr	ed	
death death stor: / the	icat	2 ☐ Accident investing 3 ☐ Suicide 6 ☐ Could	not be	Place of Injury - At	home form etr		/es 2□No	Opt Leastine (
lor A after Direc	Certification: To	4 ☐ Homicide determ	ined 206. F	building, etc. (Spe	cify)	eet, lactory, office		City or Tow	Street and Numb n, State)	er or Hura	i Houte Number,
spital ours neral filled		29a. Certifier Certifyin	ng Physician: T	o the best of my k	nowledge, deat	occurred at the tin	ne, date and place	and due to the	cause(s) and ma	enner as s	tated
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical one)	Examiner: On t	he basis of exam manner stated.	ination and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
vithir Vorip	Me	29b. Signature and title of certifie				29c. License	number		29d. Date signed	i (Month, i	Day, Year)
	Į	Junit 1:	Licens	-	>	Hoo:	544139	MID	Februar	79 .:	کی ا ل
101	Ī	30. Name and address of person	who completed	cause of death (It	em 23a) (Type,	Print)					
			arc Do	MBNO	orth Ave	barles	Bel /	tion and	21019	<u> </u>	
Stat	te	31. Date filed (Month, Den Year)	7 2010	32. Registrar's Sig	nature	barre					
Registra	ત્રા	7 33 37 48	1 -414	140,00	1. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -10.45 M Louise White -2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Overlea Health/Rehabilation n/a Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Months Days Hours Min. (Month, Day, Year Director 229-16-7014 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 本Yes 2 □ No n/a Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6120 Fairwood Ave 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 72 hours after 2 🔀 No Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal, any injury or other traumatic event, the Medical Exal. If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Black Specify: Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Supervisor Lane Bryant &. Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ernest Hodnett Ethel Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lisa Taylor/niece</u> 6120 Fairwood Ave. Baltimore, Md 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Feb.19,2010 Baltimore, Md Cemetery DakLawn gnature of uneral Service L 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 1412 E Preston б Baltimore Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ement physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: nse ' 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy Yes 2 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hearital or Attending Previous 24 hours after death. 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

31. Date filed (Month, Day, Year)

e of certifier

me and address of person who completed cause of death (Item 23a) (Type, Print)

5601-

32. Registrar's Signature

Loch

D 25391

Raven Blud, 21239

29d. Date signed (Month, Day, Year)

2-15-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death **Physician** VER cl /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.17,1955 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min Director 54 Md <u> 212-70-6052</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f showevent, if e Medical Extraitor must be redified at Director 1 XYes 2 No n/a Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2809 Chelsea Terrace 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 💆 No 1 X Never Married 2 ☐ Married Black 1 ☐ Yes 2X No If Yes. Give Specify <u>Ş</u> Specify 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker/finance Dept. Social Service permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Williams Coates Comora 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) father Bernard Williams/ <u>2809 Chelsea Terrace Baltimore, Md 21216</u> 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) GreenMountCrematory Feb.15,2010 Balto. MD 21. Signature of Funeral Service Licensee IN E. FUNERAL BALTO. PRESTON ŠT. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a d sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 1∠ mon 1∠Yes 2X No 9 ☐ Unknown Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one 2F No Other: 4 \sum Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be

The law requires that the death certificate be executed Box 68760. Ö ۵. Records, Vital Physician: of Division

death v

within 72 hours after

Baltimore, Maryland 21215-0036

signed by the a certificate this Hospital or Attending death. within 24 hours after deat To the Funeral Director: filled in by the completely To the

29a, Certifie (Check only one)

3 Suicide

4 Homicide

🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature ar

determined

Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a)

Registrar

Medical

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Marlyn Florence Wilson ebruary 20/0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner seda Samare tosb timore If Under 1Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/22/1934 6 56 Social Security Number 7. Age (In yrs. ast birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 F Yrs. Maryland Director 219-30-6114 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, It e Madical Examiner must be notified at 1 □Yes 2 XNo Maryland Essex Directo Baltimore 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? 21220 USA 65B Oak Grove Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: þ SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be Unk John Goodwin ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any injury or other trauonce. 65B Oak Grove Dr, Essex, MD, 21220 Edward A. Wilson / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Chester, 2/19/2010 R.A. Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 21. Signature of Funeral Serv 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ellar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to or as a consequence 1): Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 💢 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 No 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the

State Registrar

29b. Signature and title of certifier

man (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sig

DHMH 17 Rev 1/2001

MD

29c. License number

29d. Date signed (Month, Day, Year)

2/2/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Jean E. Angelucci</u> 6:20 A M January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Memorial Hospital <u>Havre</u> de Grace Harford 8. Date of Birth (Month, Day, 03/02/1 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours Min. Director 102/1928 220-22-3603 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Grace Harkond Havre de 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 605 Legion Drive U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telenhone Switchboard Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Austin H. Lowe Nellie Roselie Welsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Way (Daughter) 607 Chapel Terrace, Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdns 02/02/2010 Aberdeen. Maruland Signalure of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington Street, Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. L. t only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 194 No 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause (HOUAS

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Paul Aschenbach Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 100MIOD REGIONAL If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F 70 Months Days Hours 4/6/1939 Director 184-28-6752 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 ¥ Yes 2 □ No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral USA 720 139th St 21842 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: Completed 3 Divorced white Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Fuller Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emerson Paul Aschenbach Marian Moyer permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susanne Aschenbach / wife 720 139th St., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cape Henlopen Crem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 2/1/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between eart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, it cling to immediate cause. Enter Underlying Examine Due to jor as a consuluence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHF 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of cleath? 24a. Was an autopsy has le 2 page perform this certificate Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 ★ Yes 2 No Be 26. Place of Death (Check only one) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and titl 29c. License number 1+5044) 1/29/10 and address of person who completed cause of death (Item 23a) (Type, Print) 10 arroll St 100E

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of N	-	epartment of Heal		-	0010	00000
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Dea	airi	2. Date of Death	g. No.	3. Time of Death
	Physici		FRANCES BLAF	KE ALLEN			Month	Day Year 18, 2010	2:18 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Loca	ation of Death	JAN.	4c. County of Death	
-	LAGIIIII		WASHINGTON ADVENTIST HO	OSPITAL	TAKOMA	PARK		MONTGO	MERY
	Funeral			Age (In yrs. last birtho	day) If Under 1 Year If U	Under 24 Hrs. Ours Min.	8. Date of Birth (Month, Day,	9, Birth	place (State or Foreign
	Director		578-54-5719	82 Yr	s.		APRIL 28		r VIRGINIA
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	Maryl -fsho	tor	MD. PRINCE GEORGES		HYATTSVI	TIE			17∏ Yes 2 □ No
	7 28a	Director	10e. Street and Number		10f. Zip Code	ظبلبل	10	g. Citizen of What Cou	intry?
	h with		5713 43rd AVE. #4		20781			U.S.A.	
	ems deat	Funeral	11. Marital Status 12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Decedent of Hispan If Yes, specify Cuban, Me		ecify Yes or No-	14. Race - Amer Black, White,	
36	be filed within 72 hours after death with the Maryland that Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Eventinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐	X No	_	pecify:		Specify:	
2-003	hours tural"	q p	3 ☑ Widowed 4 □ Divorced Year or Date:		ecedent's Usual Occupation		T 1	6b. Kind of Business/Ir	HITE
215	in 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)		Give kind of work done during ife. DO NOT use retired)	g most of worki	ng '	ob. Killa of Busilless/il	loustry
	filed within Hygiene. other than "sent, the Mer	mo	Elementary/Secondary (0-12) College (1-4d	or 5+)	CLERK			F.B.I.	
פ	e filed al Hygi other vent, II	BeC	17. Father's Name (First, Middle, Last)	·	18. 1	Mother's Name	(First, Middle, Ma	aiden Surname)	
Maryland 21	id 2 should be f Ith and Mental I 27 is marked ol traumatic eve	70	MASON T. BI	LAKE		G]	EORGIA	WOLVERTO	N
Jar			19a. Informant's Name/Relationship (Type. Print)	19b. N	Mailing Address (Street and N	Number or Rura	l Route Number,	City or Town, State, Zi	ip Code)
	s 1 and 2 of Health item 27 i		PEGGY DEWARD/DAUGHTER		05 RIVERDALE				
altimore,	STOP		20a. Method of Disposition 17☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	ile	risposition (Name of crematory or other place)			0c. Location - City or T	own, State
ΙĦ	lit. Pa urtmer ortant njury		4 Donation 5 Other (Specify)	ARLING	TON NAT L. CE		3-2010	ARLINGTON	,VA
Ba	permit. Page Department of Important: If any injury of	ļ, ļ	21. Signature of Funeral Service Licensee	@M00091	CHAMBERS FUN	VERAL HO			
Ė			23a. Part 1. Enter the disease, or complications that caus	sed the death. Do no	5801 CLEVELA t enter the mode of dying, su-				Approximate
	Physician		shock, or heart failure. List only one cause on each		otic Corona	1.1 1	PTISON	DUENT	Interval Between Onset and Death
	/Medical		resulting in death)	as a consequence of)		Hod it	~16101	Daeibi	YEARS
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289	ficate phys s the	edical	d						
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o,	requires that the neen signed by th	by F	Part II. Other significant conditions contributing to death	but not resulting in the	ne underlying cause given in	Part I.		acco use contribute to	
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Ö	> 0 0	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u></u>	ilcian: The law certificate has ector, page 2.	Cou					perform 1 Tes 2	ed? death? BNo 1 ☐ Yes	2 3 0
<u>₹</u>	ilcian certifi ector	Be	25. Was case referred to medical examiner?		Othor	Place of Death	(Check only one,)	
ō	Phys rathis rat dii	6	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inpa 27. Manner of Death		atient 3 DOA 4		me 5 🗌 Resider 28d. Describe hov	nce 6 Other (Spec	ify)
o	ding th. : Afte : fune	tion	1 Matural 5 ☐ Pending (Month, 1) 2 ☐ Accident investigation	Day, Year) Inju				rinjury cocurred	
DIVISION	Atter	ifica	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm	, street, factory, office			eet and Number or Ru	ral Route Number,
Ē	tal or s afte al Dire ed in l	Certification:	4 nomiciae building,	etc. (Specify)		Į,	City or Town,	State)	
	ospit hour uners		29a. Certifier (Check only) 2 Medical Examiner: On the basis	st of my knowledge, o	death occurred at the time, di	late and place,	and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	Medical	one) and manner	stated.					
		Σ	29b. Signature and title of certific		29c. License num			d. Date signed (Month	
	2	ļ				5 1		JANUARY 2	1,2010
			30. Name and address of person who completed cause of TERRY JODRIE, MD 70	of death (Item 23a) (Ty 600 CARR	OLL AVENUE	TAK	OMA PA	RK, MARY	LAND
	Sta	te	31. Date filed (Month, Day, Year) 82. Regi	strar's Signature					<u> </u>
	Registr	_	JAN 2 5 2010 12	J. 10.	PLATE OF THE PARTY				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUSTIN ANN DORIS 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hospital Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** April6, 1950 1 🗆 M 2 🗆 F Months Hours Min. Director 66 2979 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director Washington DC 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funera 3692 Hayes Street NE #204 20019 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 ☐ Married ρ Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry Metropolitan (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Police Dept. Training Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H <u>0</u> Willie M. Austin should be Ulysses Moorman other traumatic 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. Doretha L. Austin-Alexander 4015 Meadow View DR. Spitland, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cem 1-29-2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Upensee

Waldorf,

Signature of Funeral Service Upensee

Waldorf, 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME Jambelly art 1. Enter the disperse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ S'EPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner AND RESPIRATORY FAILURE DNEUMONIA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit RENAL FAILURE that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ANOXIC ENCEPHALOPATHY Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ POST RESUSCITATION AFTER CADIAL ARREST 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CORONARY ARTERY DISEASE, DIABETES MELLITUS page

performed? Yes 2 N PERIPHERAL ARTERIAL DISEASE 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

or Attending

Hospital

director,

Be

Certificate:

Medical

only one

29b. Signature and title of certifier

of Vital

Division

D0062165

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

1 Yes

Month

110 21

3. Time of Death

07:34 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

MD20601

Interval Between Onset and Death

WELKS

Weeks

week

Weeks

Year

Approximate

3

Day

2 No

1 XYes 2 No

Virginia

Black

Black, White, etc.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1egene

Prince George's Hospital Cheverly, MD Teshome Zewdu Tegene

32. Registrar's Signature backs encua

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State Registrar	State	of Mary	yland / Depa	artment of F		d Mental Hy	20	110	12005
		Registrar 1. Decedent's Name (First, Middentification)	dle Last)				Dealli	2. Date of De	Reg. No. C		3. Time of Death
Physi		Joan Lawrence						01/25/2		Year	7:30 A M
/Me Exan	dical	4	on, give street and r	umber)		4b. City, Town, o	r Location of De		4c. Count	y of Death	
-É		165 Windiammer	Rd.			Berlin			Worce	ster	
Funer	_	5. Social Security Number	6. Sex 1 □ M 2 → F		n yrs. last birthday)		If Under 24 H Hours M	in. (Month, D	rth av. Year)	9. Birth	hplace (State or Foreign untry)
Directo	or	217-30-3052 Usual Residence of Decedent	X	75	Yrs.			01/2/19	935	MD	
/land		10a. State 10b. Count	у	10	Oc. City, Town or Lo	ocation					10d. Inside City Limits
Mary a-fsh	į	MD Worce	ster	В	erlin						1 □Yes 2 No
ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	untry?
ath w	200	165 Windjammer				21811			USA		
ter de items	Finera	11. Marital Status 1 ☐ Never Married 2√2 Ma	12. Was De		r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Ra Bla	ice - Amer ack, White,	rican Indian, , etc.
U36 urs aff	2	3 ☐ Widowed 4 ☐ Divorce	I ITYES (aive		1 □Yes 2≹ No	Specify:		Speci	fy: whi	ite
Z 15-UU36 hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Modical Exaninat by Indiffed at	Completed	15. Decede	nt's Education est grade completed	0	16a. Dece	dent's Usual Occup	pation	uarkina	16b. Kind of E	Business/Ir	ndustry
ithin han "	200	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)	Orking	D1		1
Hygie ther ther the	[5		l act)		stati	stical t		lame (First, Middle	Rowles		J •
YIBNG Z1 tould be filed with Mental Hygien narked other the	a B	Herbert Lawren					_	Irene Mul	· _	ne)	
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction to other traumatic event, the Medical Exactions.	F	19a. Informant's Name/Relation	ship (Type. Print)		19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City or Town	n, State, Z	lip Code)
and 2 and 2 salth s		Robert Arnold	(husband)		165 W		r Rd Bei	rlin, MD	21811		
ore of He if item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 Demoval from	n State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location	- City or T	own, State
Saltimor bermit. Pages Department of mportant: If it		4 □ Donation 5 □ Other	Specify)	State	Cape Henl				Frankfo		
Depar Depar Impor	ouce.	21. Signature of Funeral S = vi =	Licensee			2. Name and Addre				al Ho	ome
		23a Part 1 Enter the disease	or complications that	caused the		08 Willian	-				Approximate
Dhysisis		23a. Part 1 Enter the discase, of shock, or heart failure. List Immediate Cause (Fin. 1	t only one cause on	each line.	doddii Bollocoii	or the mode of dyn	ig, odor do odra	nao or roopiratory t	inoot,		Interval Between Onset and Death
Physicia: /Medica		diseas- or condition resulting in death)	a. Due to	o (or as a co	qn quence of):	cer				_	<zyrs.< th=""></zyrs.<>
Examine	er	Convention, link and diving	h (COPI	2						
p #	je i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a co	onsequence of):						
xecute and I-trans	Examine	that initiated events resulting in death) Last	c. Due to	o (or as a co	onsequence of):					\longrightarrow	
cate be executed physician and the burial-transit	dical			, (or ao a o	311004001100 01):						
	edic	J	ū								
ath cer attendin	sician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			☐ Ectopic pregnanc	N/			ate of deliv	,
cords, F.O. box of wrequires that the death certific been signed by the attending phould be detached for use as	Sici	in the past 12 month. 1 ☐ Yes 2 ☐ No		gnant at tim		Other (specify)			M	lonth	Day Year
hat the	Phys	9 □ Unknown Part II. Other significant condit	ions contributing to	death hut n	ot resulting in the u	nderlying cause giv	en in Part I	23e Did	tobacco use con	atribute to	the cause of death?
necords, ne law requires t has been signe ge 2 should be c	3	14701	one continuing to	death but in	or resulting in the d	nderlying cause giv	CITILITE ACT.				obably 4 D Unknown
w requ	Completed							24a. Was			topsy findings available
Te The law te has age 2 s	amo							auto perfo	psy ormed?	prior to co	completion of cause of
VILCII F ilcian: The certificate ector, pag	نه ا	25. Was case referred to medica	al				26. Place of D	1 □ Yes eath (Check only)	2 No	1 ∐Yes	2 No
Physici This ce	ToB		Hospital: 1	Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or:	Home 5 🖫 Resi		her (Spec	cify)
ing Pl	on:	27. Mann f Death 1 ✓ Natural 5 ☐ Pendi		e of Injury onth, Day, Ye	28b. Time o Injury	Worl		28d. Describe	how injury occur	rred	
Attending r death. ector; Afte by the fune	cati	2 ☐ Accident invest	not be	a of lainer	At home, farm, str		Yes 2□No	OOS Leastine (70		18 1 1
lor A after Direc	Certification:	4 ☐ Homicide determ	nined 20e. Plac build	ding, etc. (5	Specify)	eet, factory, office		City or To	wn, State)	per or Hui	ral Route Number,
Hospital or Attence 24 hours after death Funeral Director; stely filled in by the			ing Physician: To th	ne best of m	ny knowledge, deat	h occurred at the ti	me, date and pla	ace, and due to the	cause(s) and n	nanner as	stated.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medica	I Examiner: On the	basis of ex nner stated	amination and/or in	vestigation, in my o	opinion, death oc	ccurred at the time,	, date and place	, and due	to the cause(s)
vith vith com	Σ	29b. Signature and little of certific	3r			29c. Licens			29d. Date signe	ed (Month	, Day, Year)
		1 per	rano				Del 3 2	27	1/2	-5/11	2
AH 12		30. Name and address of person	who completed cause, 100 Pov			,	21804		,	•	
	State			Registrar's		~ury, mb	E 4 0 0 T				
Regis		31. Date filed (MoNth, Dry, Year	2010	rous	. A. D.	ake					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - State Registrar	e or iviaryia	-	rtificate of t	neann and N Death		eg. No. 2010	03996
	Physicia	an	1. Decedent's Name (First, Middle, Last)	ANGT TO				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	ARLENE 4a. Facility Name (If not institution, give street ar	ANGLEB	SERGER	4b. City. Town, or	Location of Death	JANUARY	28, 2010 4c. County of Dea	8:30 A M
	Examin	er	RAVENWOOD LUTHERAN VII			HAGERST			WASHINGT	
Ī	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ 1 ☐ M 2 ☐		s. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 14	Year) 9. Bi	rthplace (State or Foreign lountry) aryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	a Mary	ctor	Maryland Washington		Funks	town				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	ountry?
	ns 23e	Funeral	14 W. Chestnut Stree	Decedent Ever in	U.S. 13. V		734 ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Am	erican Indian,
15-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Modest Eval.	by	1 Never Married 2 Married 1 If Ye	ed Forces? ∕es 2 ⊡yNo s, Give or Dates:		fYes, specify Cuba I□Yes 2 🙀 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc. white
2-0	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	16a. Deced	dent's Usual Occup kind of work done o	ation during most of work d)	ing	16b. Kind of Busines: Board of	•
717		omp		ge (1-4or 5+))		eteria w			Educatio	
מפ	othe othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	, ,	laiden Surname)	
Maryland	ould b i Ment narkec	은	Wilbur B. Myers				Hatti			
<u>a</u>	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic evones.		19a. Informant's Name/Relationship (Type. Print M. Wayne Angleberger		1	•		-	City or Town, State, \mathtt{olon} , \mathtt{Va} .	•
Ğ,	of Hea item;		20a. Method of Disposition	20b.		sition (Name of natory or other place			20c. Location - City o	
Baltimore,	Page ment ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	rom State		n Mem.Par	i .	/10 H	agerstown	, Maryland
Ball	permit Depar Import any in		21. Signature of Funeral Service Licensee	()	. Name and Addres			FUNERAL HO	
H			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the dea					stown, Md	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		nami	1 Legne	phoma			Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a cons	quence of):	U	'	-15'		
		ě	Sequentially list conditions, if any leading to in mediate cause. Enter Underlying	e to (or as a conse	quance of):					
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events c							
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68/60 ,	tificate ig phys as the	edical	d						T.	
O. BOX	attendir for use	Physician/M	in the past 12 months?	s, outcome of preg Live birth 2□Fe Pregnant at time o Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)	у		23d. Date of d Month	elivery Day Year
rds, P	e law requires that the de has been signed by the e 2 should be detached	ģ	Part II. Other significant conditions contributing	to death but not re	esulting in the ur	nderlying cause give	en in Part I.		acco use contribute s 2 □ No 3 □ I	to the cause of death?
Hecord	The law recate has bee page 2 shou	Completed						24a. Was an autopsy perform 1 □ Yes 2	y prior to ned? death?	autopsy findings available occupletion of cause of
VITAI	certific rector,	Be	25. Was case referred to medical examiner? Hospital:			t all poal Other	26. Place of Deat			
0	g Physer this eral dil	2	27. Manner of Death 28a.	1 ☐ Inpatient 2 [Date of Injury	28b. Time of	28c. Injur	y at	me 5 Reside	nce 6 ☐ Other (Sp w injury occurred	ecify)
Slon	eath. or: Aftu	atio	2 Accident investigation	Month, Day, Year)	Injury	M 1 🗆	Yes 2□No			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. f	Place of Injury - At ouilding, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (Str City or Town	reet and Number or I , State)	Rural Route Number,
	e Hospi 24 hou e Funer letely fill	Medical	29a. Certifier (Check only one) Certifying Physician: 1 Certifying Physician: 1 Medical Examiner: On and							
	To th withir To th comp	Me	29b. Signature and title of certifier	~ 1		29c. License			9d. Date signed (Mor	
			Mangen 9880	T		128	365		1.28-	-10
3	H-8		30. Name and address of person who completed	catelse of death (Ite	em 23a) (Type, 1	Print) Street F	lages toru	u MO	21740	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 2 9 2010	32. Registrar's Sign	nature	San al d	9			
	registr	:1	SHITE NO AC LUIU	LEWINA	E	60:30				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 0050M George Anthony Aydelotte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEDICALCE Social Security Number 8. Date of Birth (Month, Day, 5 – 8 – 1 9. Birthplace (State or Foreign MD **Funeral** 7. Age (In yrs. last birthday) 1 ▼ M 2 □ F Months Days Yrs. **Director** 219-62-7685 <u> -8-1955</u> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Salisbury MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 723 Madison Street 21804 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 🗌 Widowed 4 🗀 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Blind Industries Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alfred L. Aydelotte Shirley Ann Hadder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Aydelotte/Mother 9403 Bishop Lane Rd, Berlin, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/27/2010 22. Name and Address of Facility 917 W. 21. Signature of Funeral Service Licensee Isabella St Bennie Smith Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CARDIOMYOPATTHY Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CORDNARY Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STENOSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Yes 2 No 2 🗌 No certificate 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 🗌 Yes ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending s after death.

I Director: After din by the fundamental 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in the desired at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sun Lukolas 1/25/10

Registrar

State

Box 68760

Records,

Vita

100 €.

CARNOLL St. SALISBURY Md 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BURN

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24 Allen Belle Mary January 201[']0° 5:55 A 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04 13 1918 9. Birthplace (State or Foreign Country)

Maryland 220-12-0781 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Maryland Wicomico Salisbury 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 900 Booth St. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: Specify:White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) state roads 12 secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Baker Henry Gordon Allen 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32754 Downing Rd., Delmar, MD 21875 19a. Informant's Name/Relationship (Type. Print) Coleen Chew niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐Removal from State 1 27 10 Salisbury, MD Salisbury Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final 2HEIMER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 **1** No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.

Physician

/Medical

Examiner

and as the burial-tra

sate has been signed by the attending physician page 2 should be detached for use as the buria

funeral director,

filled in by

After this

Examiner

Physician/Medical

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Completed

Be

Certification: To

Baltimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Mann of Death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Mahesha Thimmarayappa, MD 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature JAN 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 Eastern Shore Dr., Salisbury, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William K. Brendle 82-04-2870 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 980 Chesapeake Drive Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07 - 14 - 1920 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) 89 New York 219-18-3626 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Marilland Havre de Grace Harford Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 980 Chesapeake Drive 21078 United States of America Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Physcian Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Buri Brendle Althea Duckworth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn J. Brendle (Wińe) 980 Chesapeake Dr., Havre de Grace, MD 21078 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date R.A. Ferris & Co., Inc. 2/5/2010 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. 4 Donation 5 Dother (Specify) 2) Sign to of Funeral Service Licensee 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OYON an Uyr disease or condition resulting in death) Due to (or as a con equence of Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 □ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation

Physician; The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, physician the attending pl signed I has been page certificate After this certification. this Hospital or Attending 24 hours after death. Funeral Director: A filled in by the

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Iha Madical Examinar (, ust be mulfied at

72 hours after

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important; If Item 27 is marked other the any Injury or other trainmant.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

completely within 2 the

6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Whave

29c. License number

29d. Date signed (Month, Day, Year) 215110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1100 Revolution St House Gran un 210 78 Miliam ito 31. Date filed (Month, Day, Year) 32. Registrar

Registrar

Medical

29b. Signature/and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SAID BAHADORI January 24, 2010 2115 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F 84 Months Days Hours Min. 220 63 7002 01/92/8/94/92/5 Director I ranto) Usual Residence of Decedent shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director VA Fairfax Falls Church 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2230 George C. Marshall Drive #208 22043 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Caucasian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumeric. Elementary/Seconday (0-12) College (1-4 or 5+) Governor State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ali Bahadori Masouma Malek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22043 Abdollah Bahadorie (son) 2230 George C Marshall Dr #208/Falls Church VA 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) King David Mem Gardens 4 ☐ Donation 5 ☐ Other (Specify) 1/26/10 Falls Church VA 21. Signature of Funeral Service Ji ensee 22 Name and Address of Facility Advent Funeral Services Falls Church VA and Annapolis MD 23a. Part 1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line. f, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3 mos Immediate Cause (Final Physician/ disease or condition resulting in death) Lymphoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions. transplaced by the immediacause (Disease or injury Due to (or as a consequence of for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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☐ Unknown ed by the a detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I is certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes XX No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 I ER/Outpatient 3 I DOA Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Deficiency regarding regarding regarding regarding to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number D51616 01/25/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave #1300 Chevy Chase MD 20815 Nelson Kalil, MD 32. Registrar's Signature State Registrar

1/24/10

BAHADORI, SAID